Community Health Plan

Hamilton County, Tennessee

A community diagnosis document, November 2002

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The cover: Thanks to the Regional Planning Agency for the picture of the children playing (www.chcrpa.com), to the city of Chattanooga for the view of the county (www.chattanooga.gov/views), and to *Visuals*, Louis Sohn, photographer, for the photo of people walking along the riverfront.

EXECUTIVE SUMMARY

The Community Health Plan 2002 for Hamilton County, Tennessee represents an update of the original 1999 plan for improving the health of the people of Hamilton County developed by the Regional Health Council. The approach for this version of the plan follows closely the approach taken in the first community health plan. This version benefits significantly from that experience as well as from research, new data and information, and the significantly *increased involvement of community stake-holders in the planning process.*

The research findings that fueled this cycle of the planning process have reinforced the revelation from the previous plan: "many of the causes of illness, disability, and premature death for Hamilton County residents are determined by behavior and the personal choices that people make." In addition, research has uncovered trends in the health status of our population that require a community-wide response, engaging the perspectives and energies of all entities and all sectors of our society. In order to address significant improvements in the health of any community, *the total community must come to realize its corporate stake in every individual's health status and become proactively involved in contributing to the community's overall well-being*[1].

The data and the trends in this version of the community health plan indicate that the *five health priorities identified in the previous plan (obesity, diet and exercise, risky sexual behavior, tobacco use, addictions and dependencies, and health screenings) remain a significant focus for improving our community's health.* The prevalence of multiple risky behaviors among our young people continues to pose a challenge to all of us.

Moreover, significant new challenges have emerged. *Infant mortality and concomitant morbidity are a major concern for Hamilton County residents.* Infant morbidity and mortality data are a key indicator not only of health status, but also of the overall quality of life in a community, state or nation. *Disparities in health status indicators related to race, income and education were very pronounced.*

Coupled with the previous observations documenting the significant contribution of personal behavior to overall health status, the challenge before the Regional Health Council and every person of Hamilton County is to take seriously our personal stake in our individual and corporate health status. Towards implementation of these concepts, *the Regional Health Council will emphasize public policy development to impact the health status of the people of Hamilton County.* The Council will encourage partnerships between and among formerly disparate perspectives and resources to eliminate "turfdom" as a barrier to cooperation towards improving the health status of our citizens. The community health plan is a call to *a new commitment to a better quality of life on the part of every individual, family, agency, institution and system that comprise our community.*

William H. Hicks, Chairman
Regional Health Council
Hamilton County, Tennessee

[1] Richard H. Schlesinger, PhD, author of "Health is a Community Affair" and principal architect of Public Law 89-749, the "Partnership for Health" Act of 1966

PREFACE

The community diagnosis component of the Community Health Plan for Hamilton County, Tennessee is critically important to an effective health planning process. This diagnosis has helped the Chattanooga-Hamilton County Regional Health Council and the Community it represents to better understand the health status of the population and to develop strategies to address prioritized areas of need. This phase of the planning process has been essential to initiating robust dialogue related to the findings of the diagnosis and continues to advance partnerships for action among key stakeholders in Hamilton County. The analysis demonstrates that great opportunities exist in our community for individuals, organizations and institutions whose missions focus primarily on health issues and/or the provision of health services. The analysis also reflects on opportunities for local governments, businesses, family and youth-serving organizations, faith-based organizations, area schools, including institutions of higher education, neighborhood associations, and other entities whose domains focus upon many areas with a broad impact on the health of our residents.

The recent efforts toward community diagnosis in Hamilton County have encouraged local leaders and organizations to pay greater attention to strategies that promote improvements in personal decisions to promote healthier behaviors by individuals, families, and employers. The community diagnosis referenced in this document will help our Regional Health Council pursue its mission of ”serving as the lead community based organization designated by the Tennessee Department of Health to be responsible for community health assessment, regional health planning and the provision of input regarding funding decisions for health and health related initiatives.” Also, these same entities from this planning process have become more aware of the need to have strategies that relate to public policy, health education and awareness that are vital in positively impacting the health of the population. There is herein the clear indication of the importance of values, lifestyle, the home and the community environment.

The community diagnosis referenced in the document represents an important stage in a cyclical planning process. As a result, Hamilton County has a better understanding of its health status today, the potential roads to travel to improve its future and to measure health status outcomes. Ultimately, this process is designed to define and enhance what our people consider to be “positive health.”

Irvin O. Overton, Chairman
Community Health Planning Committee

ACKNOWLEDGEMENTS

The Community Health Plan Report was developed for the Chattanooga-Hamilton County Regional Health Council by the Community Health Services Office of the Chattanooga-Hamilton County Health Department. Members of the Chattanooga-Hamilton County Regional Health Council contributed to this report under the leadership of William H. Hicks, Chair of the Council, Vicky Gregg, Vice-Chair of the Council, and Irvin Overton, Chair of the Council's Planning Committee. Barbara Laymon, Community Health Planner for the Health Department, was the principal author and writer of the report, while the editing of the report was led by Bill Ulmer, Director of the Community Health Services Office.

Appreciation is expressed to the members of the Regional Health Council, its Planning Committee and its Subcommittees for their contributions to the work of the Council. The Subcommittee Chairs are James Bardoner MD, Phyllis Casavant PhD, Pat Fitzpatrick, Melony Magoon, Deborah Poteet-Johnson MD, and Viston Taylor. Acknowledgements are also offered to the members of the Health Futures Committee, chaired by Ron Blankenbaker MD, and the Information Development Committee, chaired by Susan Pollock PhD, whose work provided for important contributions this document. Much gratitude is given to Steve White and Ione Farrar, with the Community Research Council, for their contributions to research initiatives that resulted in findings referenced in the document.

A special thank-you is offered to other Health Department personnel, including Judy Pratt, for her support and technical assistance, Somini Mathew, for her work in gathering secondary data and in developing an initial design for the report, and also to Becky Barnes, the Health Department Administrator, for her support for the work of staff of the Community Health Services Office and the Regional Health Council.

The Regional Health Council, and the Health Department extends a word thanks for the technical guidance and assistance provided by Alisa Malone, Director of Community Services, and Becky Hawks, Director of Community Systems, Tennessee Department of Health.

Question about this report and request for copies should be addressed to the Community Health Services Office, Chattanooga-Hamilton County Health Department, located at 921 E. 3rd Street, Chattanooga, Tennessee, 37403. Phone contact may be made by calling (423) 209-8088, or you may e-mail Barbara Laymon at BarbaraL@mail.hamiltontn.gov. The plan will be made available on-line through the Hamilton County web site, www.hamiltontn.gov.

Mission

To serve as the lead community based organization designated by the Tennessee Department of Health to be responsible for community health assessment, regional health planning and the provision of input regarding funding decisions for health and health related initiatives.

Vision

We, the residents of Chattanooga and Hamilton County, will redesign our community, one person, one neighborhood, one institution and one system at a time through the cooperation of all people so that every person will reach his/her economic, social, spiritual, mental, emotional, and physical potential.

Values

*Spiritual Well-being

*Cultural Diversity and Inclusiveness

*Emotional and Physical Well-being

*Economic Prosperity

*Strong Families and Neighborhoods

*Educational Opportunity & Achievement

*Safe and Healthy Environment with Supportive Institutions

Chattanooga-Hamilton County Regional Health Council

Responsibilities

The responsibility of the Regional Council is to monitor the health status of residents and recommend strategies, with the involvement of physicians, hospital managers, mental health providers, allied health professionals and others, to assure the health of persons residing in Hamilton County. Specific responsibilities include:

1. Assessing the health status of the community, through the collection and analysis of secondary epidemiological data, and primary data sources, such as behavior risk surveys and stakeholder surveys.
2. Prioritizing the health needs identified from data and information collection efforts.
3. Developing a community health plan which includes recommendations for strategies that address community health needs. This includes the enumeration of goals, objectives and outcome measures, as well as recommendations for interventions.
4. Identifying key resources and the development of partnerships to foster collaborative efforts at addressing the needs of community residents, including sub-population groups, such as children, the elderly, minorities, or groups suffering from specific diseases or conditions.
5. The provision of local input in decision-making processes regarding the allocation of state and federal funding to area agencies and institutions, and the evaluation of programs and services supported by such state and federal funding.

Chattanooga – Hamilton County Regional Health Council Membership

Bill Hicks, Chairperson
Chattanooga - Hamilton County Medical Society

Vicky Gregg, Vice Chair
Blue Cross Blue Shield of Tennessee

James Bardoner, MD
Erlanger Medical Center

Ronald Blankenbaker, MD
UTC College of Medicine and Erlanger Medical Center

Willena Byrd
Education

Phyllis Casavant, Ed.D.
S.E. Tennessee Area Agency on Aging

Marilyn Davis
TN Commission on Children & Youth

Eva Dillard
United Way

JoAnne Favors
Hamilton County Commission

Jim Folkner
OptiEdit

Ed Hannah
Parkridge Hospital Nursing Office

Glenda Hood
Community Advocate

Mai Bell Hurley
Community Advocate

Deborah Poteet-Johnson, MD
T C Thompson Children's Hospital

Susan Kirk
TN Department of Human Services

Virginia Lett
Community Advocate

Melony Magoon, RN
Chattanooga Hamilton County Health Department

Ann McGintis
Hamilton County Dep't of Education

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Fortwood Mental Health Center

Ben Miller, III
EAP Care, Inc.

Reverend Bernie Miller
New Covenant Fellowship

Irvin Overton
Erlanger Medical Center

Howard Roddy
Memorial Hospital

Sheryl Rogers, RN
Hamilton County Dep't of Education

Viston Taylor
Alexian Brothers Community Services

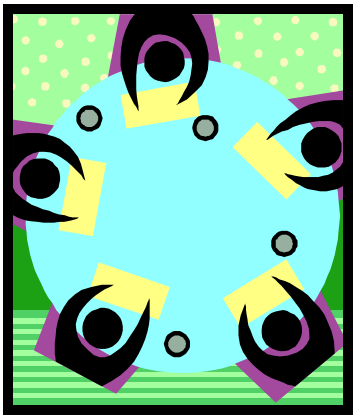
Ex-Officio Members
Chattanooga-Hamilton County Regional Health Department

Valerie Boaz, MD
Chattanooga - Hamilton County
Health Department

Becky Barnes
Chattanooga - Hamilton County
Health Department

Claude Ramsey
Hamilton County Executive

Charlotte Vandergriff
Hamilton County Commissioner



Chattanooga-Hamilton County Regional Health Council

COMMITTEES AND SUBCOMMITTEES

(Revised July 2001)

A. Executive Committee

This Committee is composed of all officers and all committee chairpersons. This committee is charged with reviewing issues that are important to the Council by providing initial insight prior to presentation to the full Council as necessary. The Council must subsequently ratify decisions made by this committee.

B. By-Laws Committee

This Committee is responsible for developing and facilitating modifications to the By-Laws and for submitting recommendations for changes to the Council for consideration.

C. Nominating Committee

This Committee is responsible for recommending a slate of officers to the Council for an election. Should a Council officer be unable to complete the elected term, the Nominating Committee shall recommend to the Council someone to fill the unexpired term.

D. Community Health Planning Committee

This Committee is responsible for initiating and maintaining an on-going community diagnosis process whereby the health and health related needs of the residents of Hamilton County are assessed. This Committee is also responsible for recommending health priorities and strategies that can address the priority areas. The community assessment processes and the work of the subcommittees of the Planning Committee are recorded in a “Community Health Plan Document” which is developed and revised by the Committee every two to three years as a requirement of the Tennessee Department of Health.

E. Health Priority Subcommittees

These Subcommittees, part of the larger Planning Committee referenced above, are established to address each of the health priorities identified as a result of need assessment processes engaged beginning with the Fall of 1995 through the present.

F. Information Development Committee

This Committee is responsible for planning and implementing community-based surveys and other data/information gathering activities. It also has responsibility for reviewing and analyzing the results of the community-wide behavior risk surveys conducted by the Council in concert with other community agencies and technical resources. The typical surveys conducted include the Adult Behavior Risk Factor Survey and the Youth Behavior Risk Factor Survey using Centers for Disease Control and Prevention survey instruments. This committee assists with interpreting the survey results and findings in preparation for public release.

G. Health Futures Committee

This Committee is responsible for developing a vision statement for the health of Hamilton County residents. This committee conducts its work by engaging in a series of activities that bring together groups of residents who broadly represent cross sections of the city and county, in order to craft or refine a health vision statement for adoption by the Council, and for subsequent adoption by residents, businesses, community organizations, the faith community, and government entities throughout Chattanooga and Hamilton County.

H. Project Review Committee

This Committee is responsible for reviewing and monitoring health programs and services as requested by the Council and/or the Tennessee Department of Health. It may also provide input into program evaluation processes. Increasingly, this committee will be asked to make recommendations to the Council and to the State regarding the local use of state, federal and or other public funds for health related programs and services.

I. Dental Care Committee

This Committee is responsible for examining dental care needs within Hamilton County. It may partner with various other organizations that have as their focus dental care and services. It may also engage in activities designed to promote collaboration and coordination of services and may assist in processes designed to procure funds in support of dental care and services, particularly those that target disparate populations.

Chattanooga-Hamilton County Regional Health Council Committees

Addiction & Dependency
Dr. James Bardoner, Co-Chairperson(*)
Pat Fitzpatrick, Co-Chairperson
Marilyn Davis (*)
Jackie Jolley
Ben Miller (*)
Rosemary Readus
Melissa Wilson
Jerry Evans
Dr. Bob Hopkins
Michele Bostwick
Sheriff John Cupp

By-Law Committee *(all members of RHC)*
Earl Medley, Chairperson
Marilyn Davis
Willena Byrd
Ed Hannah
Ann McGintis

Health Futures *(all members of RHC)*
Dr. Ron Blankenbaker, Chairperson
Vicky Gregg
Irvin Overton
Bill Hicks
Viston Taylor

Health Screenings
Melony Magoon, Chairperson (*)
Elijah Cameron
Estella Graves
Dr. Gerry Molavi-Bosworth
George Ricks
Mechelle Gant
Sheryl Rogers (*)
Velma Wilson
Brenda Martin
Walter Parks

Information Development
Dr. Susan Pollock, Chairperson
Becky Barnes (*)
Fred Carr
Ione Farrar
Dr. Gerry Molavi-Bosworth
Steve White
Viston Taylor
Dr. Kirk Walker

Project Review *(all members of RHC)*
Vicky Gregg, Chairperson
Marilyn Davis
Commissioner JoAnne Favors
Jim Folkner
Susan Kirk
Becky Barnes
Rev. Bernie Miller

Obesity, Diet & Exercise (Chatt-Fit)
Dr. Phyllis Casavant, Chairperson (*)
Ione Farrar
Debbie Kuttig
Rick O'Rear
Susan Goldblatt
Ann McGintis (*)
Kelly Lytle
Holly Griffith
Ron Strauss
Glenda Hood
George Ricks
Angela Brown
Mechelle Gant
Kimberly Ellison
Dr. Brent Morris

(*) Member of Regional Health Council

Committees, Continued

Risky Sexual Behavior
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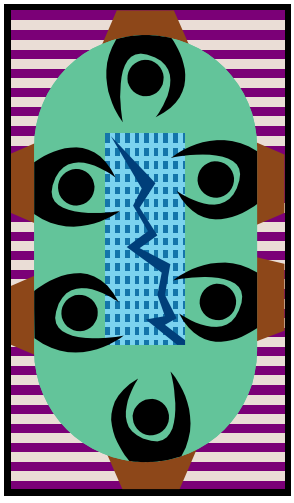
Noelle Beck
Jeanne Bille
Julie Bumgardner
Tiundra Love
Trudy Hughes
Sandra Nelson
Nancy Ridge
Paul Scott
Tiffany Smith
Marcia Swearingen
Chris Delaney
Atty. Yolanda Mitchell
Linda Williams
Yohunnah Woods-Moton
Barb Confort
Bo Walker
Rozario Slack

Tobacco
Viston Taylor, Chairperson (*)
Ben Cairns
Mark Denning
Lynda Smith
Robyn Tobias
Bill Hicks (*)
Kerrie Davis
Brenda Martin
Chris McKeever
Walter Parks
Dr. Bob Hopkins
Carlos Pride
Terri Thompson

Nominating *(all members of RHC)*
Dr. Ron Blankenbaker, Chairperson (*)
Ann McGintis
Earl Medley
Willena Byrd
Eva Dillard

Dental Care
Dr. Elenora Woods, Chairperson
Lisa Blevins
George Calhoun
Dr. Lawrence Mesich
Dr. Bill Roy
Dr. Andy Thomas

Planning Committee
Irvin Overton, Chairperson(*)
Dr. Ron Blankenbaker (*)
Dr. Phyllis Casavant (*)
Eva Dillard (*)
Commissioner JoAnne Favors (*)
Vicky Gregg (*)
Bill Hicks (*)
Dr. Deborah Poteet-Johnson (*)
Susan Kirk (*)
Virginia Lett (*)
Melony Magoon (*)
Ann McGintis (*)
Earl Medley (*)
Ben Miller (*)
Rev. Bernie Miller (*)
Dr. Gerry Molavi-Bosworth
Sheryl Rogers (*)
Viston Taylor (*)
Becky Barnes (*)
Charles Love
Dr. Zibin Guo
Dr. Marvin Ernst
Dr. Susan Pollock
Howard Roddy
Velma Wilson



(*) Member of Regional Health Council

BRIEF HISTORY OF THE COMMUNITY DIAGNOSIS PROCESS IN HAMILTON COUNTY

1994 Leaders in the health field in Hamilton County began openly to discuss the many changes that were becoming evident in the health indicators for the population of Hamilton County regarding health care financing, health and health-related resources. During the last quarter of the year, community leaders and several executives from local hospitals and the health department began to meet on regular occasions to talk about the health status of the community.

1995 Before formal "community development" initiatives were launched statewide by the Bureau of Health, key players representing the business community, higher education, health insurer groups, and others joined the small group of leaders who had been convened earlier to review and discuss the health status of the community. Their discussions were motivated by a growing interest in determining the health needs of our County residents and the need to identify resources that are required to address those needs.

The *Metropolitan Council for Community Services* convened the necessary groups to move forward the review of health needs and the identification of resources. This agency is recognized locally as the primary technical resource for facilitating community-wide research

initiatives and planning in areas inclusive of social and community services, health, and economic and community development.

The Metropolitan Council (referred to herein after as the Community Health Task Force or Task Force) organized the *Greater Chattanooga Community Health Task Force.* The purpose of this task force was to initiate efforts that would result in an improvement in the health of the residents of Hamilton County.

An assessment process conducted by the Community Health Task force included the analysis of data and information gathered from three sources: (1) a community profile analysis as documented by Metropolitan Council for Community Services in their research report entitled "Life in Hamilton County: Indicators of Community Well-Being," (2) an inventory of health resources and services, and (3) a telephone survey of 816 adults, age 18 and over, from randomly selected households in Hamilton County.

The findings that emerged from the analysis of data and information led the Task Force to conclude that *personal choices and decisions*, and *the behavior of people* are the primary determinants of premature death among residents of Hamilton County. These conclusions prompted the Task Force to establish a two-fold strategy to improve health among area residents: (1) *reduce risks,* and (2) *expand opportunities.*

1996 In October the Advisory Board of the Chattanooga-Hamilton County Health Department was reconstituted. The duties and responsibilities of the board were expanded and assigned to the newly established *Chattanooga-Hamilton County Regional Health Council,* (herein after referred to as the Regional Health Council).

1997 The Community Health Task Force assumed a lead role in planning a data collection project that would yield the identification of important issues and the needs of youth residing in Hamilton County.

1998 The Regional Health Council and the Health Department gave support to the Community Health Task Force for their lead role in conducting a survey of all Hamilton County public high school students. A survey instrument developed by the Centers for Disease Control and Prevention was used. The survey was conducted during the Spring of 1998. In August, 1998, the Task Force published a report on the findings of the youth survey, entitled A Report on Risky Behaviors Among Teens in Hamilton county's Public High Schools.

1999 In May the Board of Directors for the Metropolitan Council for Community Services dissolved the Community Health Task Force, in recognition of the mission and scope of work of the newly established local Regional Health Council.

The newly formed Regional Health Council subsequently established a Community Health Planning Committee. This Committee initiated processes and work that furthered the efforts already begun by the Community Health Task Force and the Metropolitan Council for Community Services.

Many members of the Task Force were integrated into the Regional Health Council, either as Council members or as members of the Council's Planning Committee. The role of the Community Health Planning Committee was determined to be *to engage in an on-going community diagnosis process with respect to assessing the health status of residents in Hamilton County, and to recommend strategies for addressing the needs that emerged from the on-going community diagnosis process.*

The Regional Health Council established five health priorities based on the findings from research conducted in 1995 by the Metropolitan Council for Community Services and the Community Health Task Force. These findings (which emerged from primary and secondary data) were included in a Community Health Plan Document that was developed and printed in June 1999.

The Council began the process for a reassessment of the Hamilton County population. The Council partnered with the Metropolitan Council

for Community Services to conduct an Adult Risk Behavior Survey using a Centers for Disease Control and Prevention instrument. A network of organizations, institutions and agencies funded this project. The survey was administered in the Fall of 1999.

2000 The Regional Health Council formed subcommittees around each of the five health priority areas. Each subcommittee consisted of representatives from other organizations, and the lay community. Each developed strategies for reducing risky behaviors that contribute to premature death or disability.

The findings of the Adult Risk Behavior Survey were released through a series of ten health briefings and press conferences throughout the year, beginning in February 2000.

2001 The Regional Health Council Health Priority Subcommittees continued to implement their respective community strategies through awareness, education, and advocacy initiatives.

The Regional Health Council initiated planning for a repeat survey of Hamilton County public high school students in the Spring 2002. Efforts were initiated to include private high schools also. A major fund raising strategy was developed and implemented by the Council to generate funds to support the proposed survey project.

2002 The Regional Health Council under an arrangement with the Community Research Council (formerly the Metropolitan Council for Community Services) administered the Youth Survey in March and April 2002. The survey was administered in all Hamilton County public high school and in three private high schools. The findings were made public in October 2002 in a report entitled Choices: A report on Risky Behaviors Among Hamilton County Teens.

The Community Health Plan for Hamilton County was also revised in 2002. This project was completed in November 2002. The findings highlighted in this report are scheduled for public release in January 2003.

Regional Health Council
Evaluation, Reassessment and Prioritization

EVALUATION

The Regional Health Council conducted a Self Assessment Survey in June 2002. The findings were presented and discussed at the Council's July meeting. The following categories were included:

- *Membership*

The Regional Health Council discussed the role of the Nominating Committee in assuring appropriate representation of the community. Regional Health Council members were encouraged to take advantage of the flexibility of the current structure of committees and subcommittees when new members are sought.

- *Bylaws*

The Regional Health Council reviewed and revised its bylaws in August 2002.[2]

- *Meeting Review*

There was general consensus that the location and time of the meetings was comfortable and convenient. The decision to offer healthy choices for the Council's luncheon meetings was widely accepted and cited as a vehicle to promote lifestyle change at a personal level.

[2] See Appendix

- *Subcommittees*

It was generally thought that the subcommittee structure works well to focus on particular priorities; however, active participation on some committees was deemed less than optimal, with consequent difficulties in fully implementing some strategies as designed. It was determined that the subcommittees should increase their focus on advocacy and policy development activities as a means to better influence systems and institutions that support our communities.

- *Evaluation of Effectiveness*

The Regional Health Council considered the health priorities and corresponding implementation strategies very effective. Some concern was expressed about the lack of utilization of the health plan by community agencies and institutions. An overall concern that time constraints of a small staff and a volunteer board limit the broad vision of the Regional Health Council was identified. It was determined that greater opportunities will be sought to partner with neighborhood associations, other citizen groups, faith-based institutions and other organizations, in promoting the Council's vision and its strategies.

REASSESSMENT

According to the three-year cycle described in the community diagnosis guide (year 1 for assessment, year 2 for planning and implementation, year 3 for evaluation), the year 2003 is the appropriate time frame for a reassessment of

priorities. The Council has already begun looking at its overall effectiveness as a change agent in Hamilton County and is considering possible revisions regarding health priority areas and strategies.

- *Vision*

The Regional Health Council named a Health Futures Committee to look broadly at issues of vision and mission. The Council's vision is presented on page 1. The Committee has begun planning for a Community Health Summit 2003 for the Chattanooga-Hamilton County area. This major project will serve as a forum for community leaders and lay persons to discuss issues that affect the health of our population. It will also allow for new strategies to be identified that would address the problems that influence the health of our residents.

- *Data*

The Regional Health Council identified baseline data to measure change towards targeted objectives in the health priority areas. Data on health behaviors are provided from the Community Research Council[3], a local agency dedicated to "turning data into information," which periodically conducts adult and youth behavior risk surveillance surveys[4]. Mortality data in this document are from the Tennessee Department of Health[5] (unless otherwise indicated) and reflect resident statistics only. Other health related data are continually reviewed from a variety of local, state and national sources.

[3] Formerly the Metropolitan Council of Community Services.
[4] The 1999 Adult Behavior Risk Factor Surveillance Survey (BRFSS) and the 2002 Youth Behavior Risk Surveillance Survey (YBRFSS) are referenced frequently in this document.
[5] Accessed through the University of Tennessee's Health Information Tennessee (HIT) site, www.hitspot.utk.edu

PRIORITIZATION

Through a consensus process, the Regional Health Council identified Health Priority Areas, and named subcommittees to focus on each area. These subcommittees included: 1) Obesity, Diet and Exercise 2) Risky Sexual Behavior 3) Tobacco Use 4) Addictions and Dependencies and 5) Health Screenings.

- Intervention Development

As priorities were developed, the Regional Health Council's subcommittees began developing strategies and plans for interventions in the community. The specific planning, design, and implementation of strategies for each subcommittee are described next. Each subcommittee developed its own objectives and implementation strategies. Timeframes for action and evaluation are currently under development.

Health Priority Area

OBESITY, DIET AND EXERCISE SUBCOMMITTEE

Phyllis Cassavant, Ph.d
Subcommittee Chairperson

GOAL

To promote healthier lifestyles among residents of Hamilton County by advocating and planning for activities and policies that encourage and support healthier eating and exercise practices as a means to reduce morbidity, disability and premature mortality.

OBJECTIVES AND ACTIVITIES

Objective #1

Increase to 85% the proportion of Hamilton County residents aged 18 and older who engage in any leisure time physical activity.

Baseline: 77% in 1995 (Local Adult Behavior Risk Survey, 1995)

Target: 85%

Awareness Activities:

- Disseminate awareness information in schools, employee newsletters at area businesses, college newspapers, and movie PSA's.
- Submit awareness information to churches, (ministerial groups, church nursing guilds, and other church organizations.)
- Employee paycheck envelops slips (for health messages) – Target large businesses and small businesses.

- Distribute awareness information through Neighborhood Associations.

Educational Activities:

- Distribute health education literature on healthy eating practices and exercise routines, at grocery stores, at neighborhood association meetings, at local malls and other businesses
- Promote the dissemination of health education materials in churches.
- Promote and facilitate Health Risk Appraisal Programs within the community (at neighborhood association planned events)

Advocacy Activities:

- Advocate among City officials for the creation of greater opportunities for residents to access community recreation facilities in evenings and on weekends.

Objective #2

Increase the proportion of public and private elementary, middle and high schools that require and provide daily physical education for all students.

Baseline: 81 public schools offer physical education classes 2 days per week in 1999 (Local Hamilton County School System)

Target: 81 public schools to offer daily physical education classes or activities.

Awareness Activities:

- Submit information to the County School System and to private schools expressing RHC's interest in increased PE activities.
- Offer assistance to schools in identifying resources to provide assistance within schools for PE activities.

Educational Activities:

- Partner with local youth organizations to promote increased involvement of youth in physical education or exercise activities.
- Disseminate promotional materials at recreation facilities and at sporting events.
- Disseminate educational materials and information at churches, particularly those with strong youth programs, as well as at neighborhood association meetings.

Advocacy Activities:

- Explore and advocate for an increase in the frequency of PE offerings at each school within the County School System and within private schools.

Health Priority Area

RISKY SEXUAL BEHAVIOR SUBCOMMITTEE

Dr. Deborah Poteet-Johnson
Sub-Committee Chairperson

GOAL

To reduce the extent of risky sexual behavior practices among residents of Hamilton County that would in turn assist in reducing the incidence of teen pregnancies and other unintended pregnancies, sexually transmitted diseases, HIV, rape and other personal attacks and violations.

OBJECTIVES AND ACTIVITIES

Objective #1

Reduce to no more than 25% the proportion of individuals aged 15-17 who have ever had sexual intercourse.

Baseline: 58% in 1998 (Youth Behavior Risk Survey, 1998)

Target: 45%

Awareness Activities:

- Distribute STD posters in local stores, service stations, malls, recreational facilities, bowling alleys, and at sports events.
- Disseminate awareness information to parents via PTA meetings, mail-outs, and at sporting events.
- Letters to physicians encouraging attention to youth victimization issues revolving around youth sexual activeness.
- Presentations to youth groups

- Request pediatric medical staff to conduct awareness classes and seminars for youth and parents.

Educational Activities:

- Establish media literacy campaign.
- Endorse current efforts of STARS, Y-kNOw, Girls Inc., Boys Club, Girl Scouts, and Big Brothers/Big Sisters, to address teen abstinence efforts.
- Encourage school system to increase sex education and awareness programs.
- Promote increased educational initiatives within the juvenile justice system.
- Promote motivational interviewing among providers.

Advocacy Activities:

- Investigate and explore legislative interpretation regarding “age of consent” legal definition.

Objective #2

Reduce pregnancies among females aged 15-17 to no more than 45 per 1000 adolescents.

Baseline: 38.4 per 1000 adolescents aged 15-17 in 1996 (Healthy People 2010 National Data)

Target: 35 per 1000 adolescents

Awareness Activities:

- Encourage an increase in the airing of appropriate TV and radio public service announcements regarding abstinence.
- Support and facilitate presentations to youth groups.
- Support and offer assistance with the efforts of youth organizations in increasing awareness of risky sex issues.
- Request pediatric physicians and social service providers to increase their counseling efforts with youth around risky sexual behavior issues.

Educational Activities:

- Disseminate educational materials and information at churches through men's ministry organizations.

Advocacy Activities:

- Explore effectiveness of family planning services for teens.

Objective #3

Reduce pregnancies among unwed females, aged 18-24 to 25% or less.

Baseline: 36.1% in 1999 (Comm. Research Council [Local data])

Target: 25% or less

Awareness Activities:

- Disseminate awareness materials to UTC fraternities and sororities.
- Facilitate and coordinate presentations at area businesses regarding healthy relationships and victimization issues.

Educational Activities:

- Media literacy campaign
- Promote and facilitate educational campaigns on the campus of UTC and Chattanooga State.
- Presentations and educational sessions within church organizations that focus on young adults.
- Presentations and educational materials disseminated at public housing developments.

Advocacy Activities:

- Promote disincentives for young women to receive welfare benefits.

Objective #4

Increase awareness of the role sexual victimization plays in risky sexual behavior by assessing numbers of individuals having sexual intercourse by age 13 and by numbers of individuals who admit sexual activity under duress. (Forced Intercourse)

Baseline: 9% of youth surveyed reported forced intercourse (Local YBRS, 1998)

Target: 5% or less

Awareness Activities:

- Disseminate information and awareness materials on date rape to UTC fraternities and sororities.
- Encourage physicians and other providers to be sensitive to and provide counseling to patients regarding victimization issues.

- Establish resource clearinghouse

Educational Activities:

- Media literacy campaign
- Promote educational seminars and special presentations on college and university campuses.

Advocacy Activities:

- Encourage enforcement of laws protecting minors as it relates to incest, date rape, sexual battery, and sexual harassment.

Health Priority Area

TOBACCO USE SUBCOMMITTEE

Viston Taylor
Subcommittee Chairperson

GOAL

To reduce the extent of tobacco use among residents of Hamilton County by advocating and planning for services, interventions, prevention activities and policies that encourage and support behavior change regarding tobacco product use as a means to reduce morbidity and premature mortality.

OBJECTIVES AND ACTIVITIES

Objective #1

Reduce to no more than 13% the proportion of adults (18 and older) who use tobacco products.

Baseline: 25% in 1995 (Local Adult Behavior Risk Survey, 1995)

Target: 13%

Awareness Activities:

- Disseminate awareness information in schools, businesses, and throughout the community about the dangers of tobacco use and second-hand smoke.
- Submit awareness information to churches, (ministerial groups, church nursing guilds, and other church organizations.)

- Employee paycheck envelops slips (for health messages) – Target large businesses and small businesses.
- Distribute awareness information through Neighborhood Associations.
- Distribute awareness information at local sporting events.

Educational Activities:

- Distribute health education literature on tobacco product use in schools, at grocery stores, at neighborhood association meetings, at local malls and other businesses.
- Promote the dissemination of health education materials in churches.
- Request and promote the presence of trained facilitators in schools to deliver smoking cessation seminars and classes.
- Coordinate tobacco prevention programs /activities
- Assist businesses in becoming smoke free.

Advocacy Activities:

- Advocate for an increases in taxes on tobacco products (proposed increase to 21%)

Objective #2

Reduce the proportion of young people in grades 9 through 12 who have used tobacco products.

Baseline: 35% in 1998 (Local YBRS, 1998)

Target: 28%

Awareness Activities:

- Conduct media campaign on the dangers of tobacco product use among youth.
- Submit information to churches and other community organizations serving youth.
- Provide information to Neighborhood Associations and coordinate health presentations at neighborhood association meetings.
- Disseminate information on tobacco product use at school sporting events.

Educational Activities:

- Partner with local youth organizations to promote non-tobacco use among the youth service recipients.
- Disseminate educational materials in schools, at recreation facilities and at sporting events.
- Disseminate educational materials and information at churches, particularly those with strong youth programs.

Advocacy Activities:

- Promote and advocate for increase in taxes on tobacco products.

Health Priority Area

ADDICTIONS AND DEPENDENCY SUBCOMMITTEE

Dr. James Bardoner, Co-Chairman
Pat Fitzpatrick, Co-Chairman

GOAL

To improve the overall health of the community by promoting healthy lifestyles through prevention, identification, education, and advocacy of the risk associated with alcohol and other drug abuse, and to promote the reduction of practices associated with other forms of addictions and dependency.

OBJECTIVES AND ACTIVITIES

Objective #1

Reduce past month use of alcohol among adolescents age 12 to 17 years by 5%.

Baseline: 41% in 1998

Target: 36%

Objective #2

Reduce past month use of marijuana among adolescents age 12 to 17 years by 5%

Baseline: 24% in 1998

Target: 19%

Objective #3

Reduce the percent of adolescents, age 12 to 17 who have ever used other illegal drugs

Baseline: 16% in 1998

Target: 10%

Objective #4

Reduce the percent of adolescents, age 12 to 17 who have ever used inhalants.

Baseline: 20% in 1998

Target: 15%

Objective #5

Promote an increase in the awareness level of the dangers associated with the inappropriate use of prescription and over the counter drugs.

Baseline: None

Activities Under Development

Health Priority Area

HEALTH SCREENINGS SUBCOMMITTEE

Melony Magoon
Subcommittee Chairperson

GOAL

To promote the early identification of health problems among residents of Hamilton County by advocating and planning for health screening initiatives, planning and coordinating health education campaigns, and by advocating for public policies, practices, and laws that support preventive health measures that reduce morbidity and premature mortality**.**

OBJECTIVES AND ACTIVITIES

Objective #1

Increase the proportion of adults with diabetes whose condition has been diagnosed.

Baseline: 68% of adults aged 20 years and older with diabetes had been diagnosed in 1988-94. (Health People 2010 National Objectives)

Target: 80%

Awareness Activities:

- Submit information to the Newspaper Events Calendar regarding health observances
- Submit information to Church calendars, bulletins, nursing guilds, and other church organizations.

- Employee paycheck envelops slips (for health messages) – Target large businesses and small businesses.
- Distribute awareness information through Neighborhood Associations.
- Distribute awareness information at local sporting events.
- Disseminate awareness information to providers.

Educational Activities:

- Partner with and promote hospital-based diabetes health education programs
- Distribute health education literature at grocery stores and at local malls
- Promote the dissemination of health education materials in churches.

Advocacy Activities:

- Request and promote an increase in the amount of physical education classes in local public school system.
- Request school officials to increase the number and variety of nutritional food and beverage offerings and reduce those that have poor nutritional value in vending machines on school property.
- Promote and advocate for legislation and policies or changes in legislation or policies that would increase coverage by the insurance industry for all preventive health screenings.
- Promote increased screening for blood sugar during routine physicals for youth.

Objective #2

Reduce the prostate cancer death rate among Hamilton County residents.

Baseline: 32 age adjusted per 100,000 standard population of males in 1998. (Health People 2010 National Objectives)

Target: 28.8

Awareness Activities:

- Submit to the Newspaper Events Calendar prostate cancer information during cancer awareness month
- Submit information in employee paycheck envelops on prostate cancer – target businesses with large male employee work force.
- Submit information to church calendars, bulletins, nursing guilds and other organizations
- Provide information to Neighborhood Associations and coordinate health presentations at neighborhood association meetings.
- Disseminate information on prostate cancer at school sporting events.

Educational Activities:

- Partner with and promote hospital sponsored special prostate cancer screening clinics
- Disseminate educational materials in barber shops.
- Disseminate educational materials and organizations.

Advocacy Activities:

- Promote increased prostate cancer screenings by providers, including greater participation in free community-based screening initiatives.

Hamilton County: A Health History[6]

People have lived in the Chattanooga - Hamilton County area since around 10,000 BC. By the late 1700's, smallpox brought by European settlers had decimated the Native American population. Most remaining Indians were relocated in the 1830's by the infamous Trail of Tears. The Civil War and policies of the Reconstruction era left a host of problems related to low income and lack of education that continue to plague the area. In the twentieth century, increases in chronic disease paralleled the general pattern of the country.

Several further developments of the last century are important to the general health of the people of Chattanooga. The work of the Tennessee Valley Authority during the Great Depression made the Tennessee River, which flows through Chattanooga, navigable and manageable, and brought new opportunities for economic prosperity to the area. The Civil Rights movement reframed the structure of the community and brought hope of equal opportunity for all. Later in the century, a focus on the environment changed the highly industrialized Chattanooga from a polluted city to an area with an excellent air quality index. As the 21st century begins, however, a variety of health status and environmental concerns continue to exist, and reside disproportionately among the County's poor.

[6] Sources for this section include *Sequatchie: A Story of the Southern Cumberlands* by J. Leonard Raulson and James W. Livingood. Knoxville: University of Tennessee Press, 1974. *A History of Air Pollution Control in Chattanooga in Hamilton County*, Air Pollution Control Bureau, revised 1999.

Demographics[7]

Hamilton County[8] is the 4th most populated region of Tennessee. Some general demographic facts include:

- The County's population has grown 7.8% since 1990, or at about half the rate of the state as a whole (Table 1 on facing page).
- Persons age 65 and over make up 13.8% of the county's population, over 1.5 % higher than the state's proportion of Seniors.
- The population is about 20% Black and 76% White.
- Although making up a small percentage of the total population, the number of people of Hispanic or Latino origin has tripled[9] since the 1990 census.[10]
- Persons living below the poverty level make up about 13% of the county's population, but almost a third of the Black population.
- About one in five people ages 25 years and older has not completed high school.

Demographic indicators, such as education, income, and age distribution of the Hamilton County community, are of particular concern for community health planning.

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[7] All data are from the Census Bureau unless otherwise indicated.
[8] Hamilton County contains 542 square miles of land and is part of the Chattanooga, TN-GA Standard Metropolitan Service Area.
[9] Sources in the Hispanic community consider these numbers vastly under reported.
[10] ***Healthy People 2010*** notes that Hispanics are twice as likely to die from diabetes than non-Hispanic Whites, have double the incidence of tuberculosis than the total population, and also have higher rates of high blood pressure and obesity than the non-Hispanic White population (page 12).

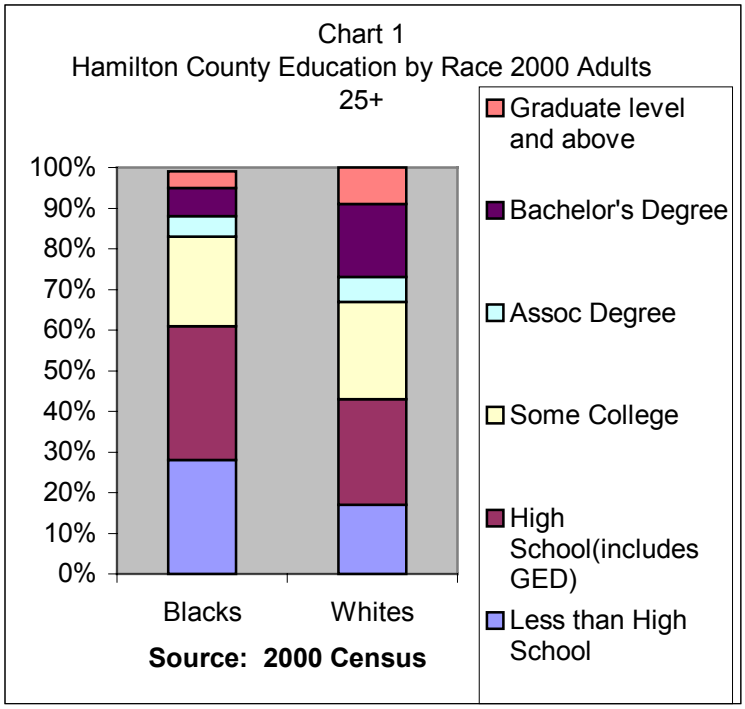
Table 1

PeopleQuickFacts[11] 2000 Census	Hamilton Co	TN
Population, 2000	307,896	5,689,283
Pop % change, (1990 to 2000)	7.8%	16.7%
Persons under 5	6.0%	6.6%
Persons under 18	23.2%	24.6%
Persons 65 & older	13.8%	12.4%
White Persons	76.3%	80.2%
Black Persons	20.1%	16.4%
All Other Races	3.6%	3.4%
Hispanic Origin	1.8%	2.2%
Median Income	$34,836	$32,047
Below Poverty (1999)	12.1%	13.5%
Less than high school (Among persons 25 and older)	19.1%	24.1%

[11] Source: quickfacts.census.gov

Education

In Hamilton County, about 17% of the White population and 29% of the Black population have less than a high school education (Chart 1). About one in four Whites and one in ten Blacks has a bachelor's degree or above.

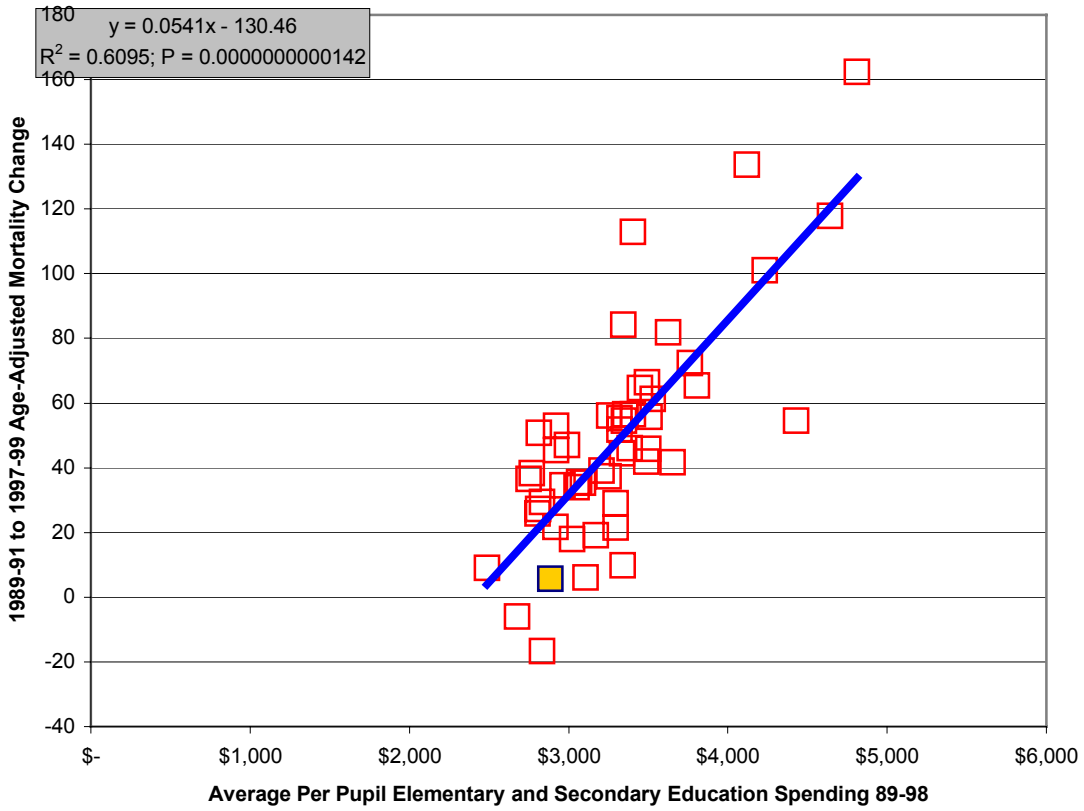


In Hamilton County, poor children did about half as well as nonpoor children on reading ability.[12] Such statistics point to a lack of readiness for school work. The 2002 TN Association for the Education of Young Children Conference[13] referenced the growing convergence of research from many disciplines about the importance of early childhood education. Education and health are closely related. Figure 1 shows the association between change in mortality and per-pupil spending for elementary and secondary education by state.

[12] Source: TCAP 3rd grade reading scores, 2002.
[13] October 10, 2002 TAEYC conference, Chattanooga, TN, with Neal Halfon, MD, MPH, (University of California at Los Angeles)

The relationship[14] between investment in education and improvement in mortality rates is highly significant. The issue of education is of particular importance in Tennessee where, as shown in Figure 1 (solid orange box), the state is near the bottom in the level of education investment. It is quite clear that further investment in education would have potential to improve health in Tennessee.

Figure 1
Education Spending and Health by State[15], United States, 1989-98



The relationship between health care spending and education spending from 1989-1987 was also found to be highly significant – the lower the education spending, the higher the health care spending.

[14] Source: Information on this page from BlueCross BlueShield of TN 2002.
[15] Source: BlueCross BlueShield of TN 2002. TN is solid orange box.

Income[16]

The median household income in Hamilton County is $38,930: about $3000 lower than the median income for the nation. Within the county, income varies widely by race (Chart 2), with Blacks about three and a half times as likely to be poor as Whites.

Chart 2
Income in Hamilton County, 1999

	Black	White
Below poverty	27.7%	7.9%
Per capita income	$13,569	$23,985

Income disparities by race are also found in other metropolitan areas of Tennessee (Chart 3). The disparity between Black and White income is actually less in Hamilton County than in either Davidson or Shelby County, due mainly to a lower White per capita income in Hamilton County.

Chart 3
Per Capita Income in 1999 (Dollars)
Selected Counties in TN

	Hamilton Co	Davidson Co	Knox Co[17]	Shelby Co
Black	13,569	14,509	12,610	13,207
White	23,895	27,319	22,935	29,086

Studies show[18] that the states in the US that have a high degree of income equity (a small gap between the richest and the poorest) have lower mortality rates than the states that have low income equity.

[16] Source: 2000 Census
[17] The large University of Tennessee student population in Knoxville may impact these numbers.

Age Distribution

Hamilton County has the highest proportion of elderly of any metropolitan area in Tennessee. Almost 14% of the county's residents are over 65, compared with a statewide 12.4% over 65. Although the county's population grew at only half the rate of the state's in the 1990's, the growth in numbers of elderly 75 and over has matched the statewide trend (Chart 4).

Chart 4
Hamilton County and TN Population Change, 1990 –2000

	Hamilton Co 1990	Hamilton Co 2000	Change 1990-2000	TN Change 1990-2000
Under 5	18,946	18,444	-2.6%	13%
65-74	21,906	22,652	3.4%	7%
75-84	12,574	14,717	17%	18%
85+	3,856	5,240	36%	37%
All	285,536	307,896	7.8%	16.7%

Source: 1990, 2000 census.

The elderly population of Hamilton County represents a challenge to the health care delivery system. A complete review of the health care infrastructure – including hospital and nursing home beds as well as health care personnel to staff them – may be required soon and may already be needed, with major local hospitals already operating at full capacity.

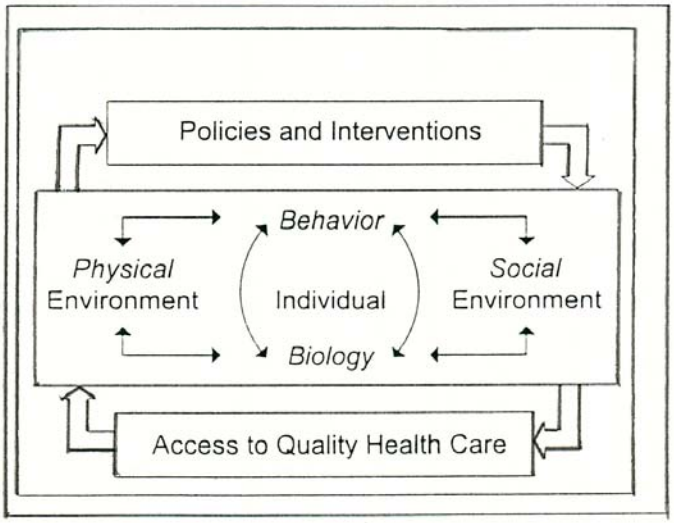
[18] Mustard, Fraser J. "Why Some People Get Sick and Others Don't." *HealthCare Forum.* November/December 1997. Mustard concludes that "the states with a high degree of income equity also have the highest degree to trust, of social capital. They are more cohesive societies… this correlation between morality , trust and income equity is, I believe, fed by the dynamic effects of communities on children." (p.17).

Health Status Indicators

Life expectancy and mortality rates are two general indicators of the health of a population. In Hamilton County, heart disease, cancer and stroke are the three leading causes of death (Table 2), following national trends. Life expectancy is 75 years: 2 years less than the national life expectancy of 77.

Life expectancy for Blacks in Hamilton County is seven years less than for Whites. Although some of the differences in health status between the Black and White populations may be attributable to genetic or biological factors, in general, inequalities in income and education underlie many of the health disparities of the people of Hamilton County. Higher education promotes higher income; higher income permits increased access to medical care, better housing in safer neighborhoods, and increased opportunity to engage in health-promoting behaviors.[19]

Determinants of Health[20]



[19] Healthy People 2010, Volume 1, page 12
[20] op. cit., page 6

Table 2

Hamilton County Selected Health Indicators

	ALL	Black	White
Average Life Expectancy[21]	75	70	77
1998-2000 Annualized Age Adjusted Deaths Per 100,000[22]**:**			
Total Deaths	957	1297	869
Heart Disease	285	385	259
All Cancer	215	285	197
Stroke	68	95	61
Chronic Lower Respiratory Diseases	49	50	48
All Accidents	41	39	41
Influenza & Pneumonia	27	32	25
Diabetes Mellitus	25	52	20
Atherosclerosis	22	**	21
Alzheimer's Disease	22	**	22
Suicide	12	**	14
Kidney Disease	9	25	*
Homicide	8	23	*
Unspecified Infections (Includes HIV)	4	26	*

*Not in top 10 causes of death for Whites
**Not in top 10 causes of death for Blacks

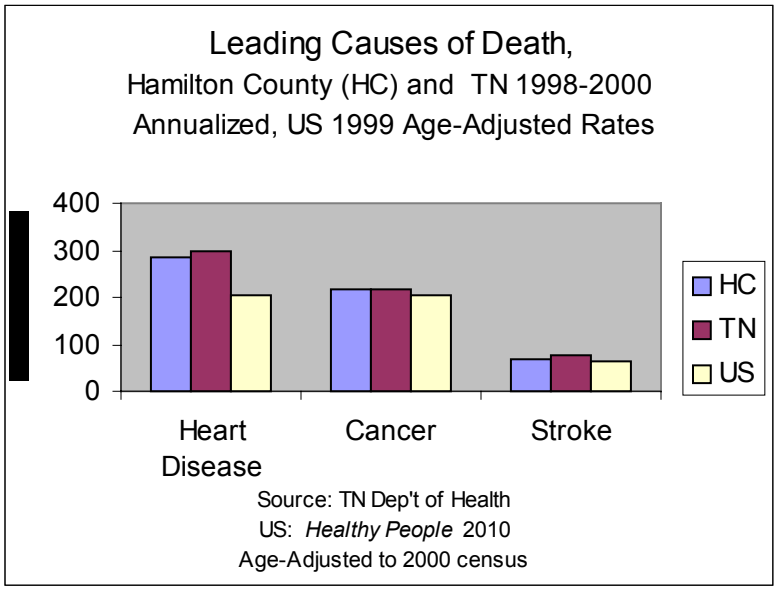
[21] United States Department of Health and Human Services, 1998
[22] Tennessee Department of Health

Leading Causes of Death

County, State and National Comparisons

A general picture of health status can be gained through a review of mortality due to heart disease, cancer, and stroke, the three leading causes of death both locally and nationally. The rate of death from heart disease in Hamilton County is similar to the statewide mortality rate, and significantly higher than the national rate (Chart 5), while rates of death from cancer and stroke are only slightly higher than national figures.

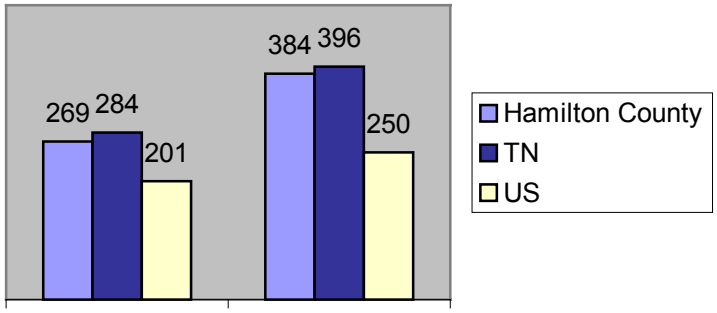
Chart 5



Race-Specific Mortality Rates

Blacks in Hamilton County are about one and one-half times as likely to die from Heart Disease as the population of US Blacks; Whites in Hamilton County are about one and one-third times as likely to die from Heart Disease as the population of US Whites (Chart 6). Rates of cancer and stroke are also higher among Blacks in Hamilton County than Blacks nationwide (not shown)[23], although the differences are less striking. Rates of cancer and stroke among Whites in Hamilton County are similar to Whites nationally.

Chart 6
Heart Disease Mortality Rates by Race
Hamilton County, TN 1998-2000, US 1999



Sources: TN Department of Health, HIT site
US: Healthy People 2010
Rates per 100,000 population
Age-adjusted to 2000 census

A large disparity between mortality rates from Heart Disease for Blacks and Whites exists at the county, state and national level. In Hamilton County, Blacks suffer a heart disease mortality rate 1.4 times the White rate. Age-specific mortality information, giving a more detailed picture of the health of the population, follows next.

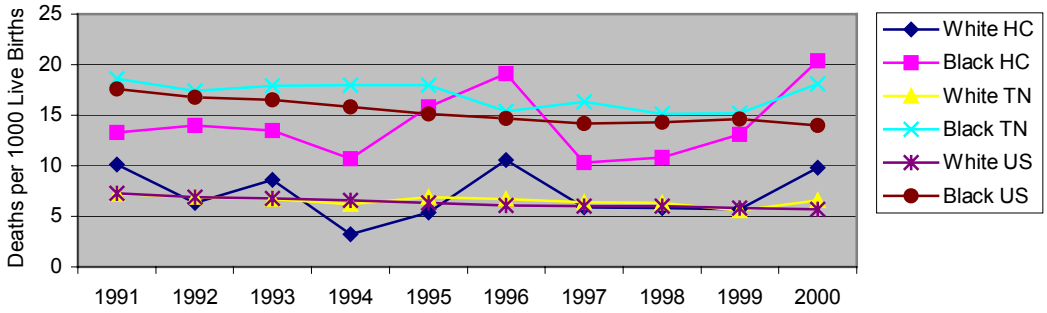
[23] The cancer mortality rate is 285 per 100,000 population among Hamilton County Blacks versus 254 among Blacks nationally. The stroke rate is 95 in the county versus 82 nationally.

Age-Specific Mortality

INFANTS

Infant death is a critical indicator of the health of a population,[24] reflecting the overall state of maternal health as well as the quality and accessibility of primary health care. Nationally, infant mortality has steadily decreased over the last decade.[25] In Tennessee, Black infant mortality has remained fairly constant and White infant mortality has slightly declined; however, in Hamilton County, infant mortality has increased for both the Black and White populations[26] (Table 3).

Table 3
Infant Mortality Rates Hamilton County, TN and US, 1991-2000



Source: TN Department of Health, CDC

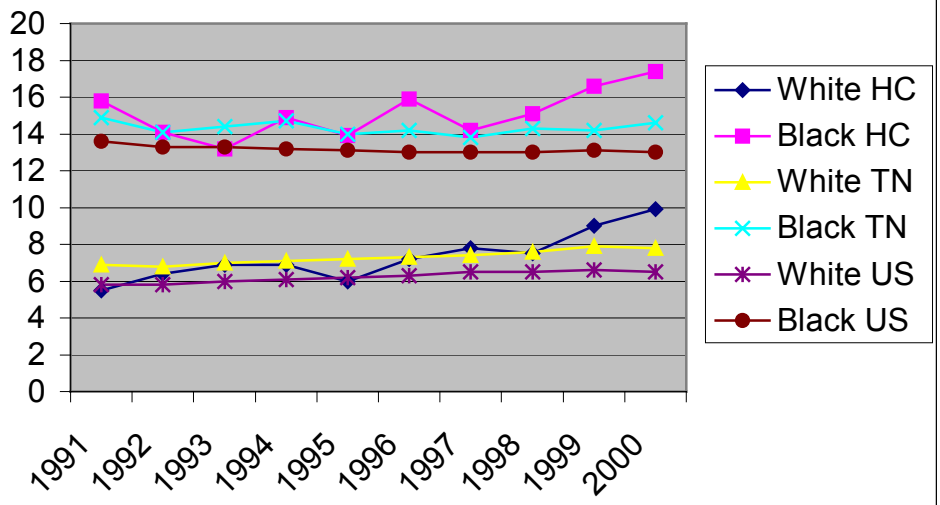
The Hamilton County Black infant mortality rate in 2000 was twice as high as in 1990. The most recent Hamilton County White infant mortality rate (2000) was 9.8; in 1990 it was 7.1. Disparities between Black and White infant mortality are high. At the national level, infant mortality occurred about 2.4 times more

[24] ***Healthy People 2010***, Volume 2, page 16
[25] ***MMWR,*** Volume 51 No.27 July 12,2002. In the US, infant mortality (per thousand live births) has declined from 18.0 to 14.0 for Black and from 7.6 to 5.7 for Whites between 1990 and 2000.
[26] All infant mortality data are from the Tennessee Department of Health and reflect resident statistics; that is, they include only those infants born to mothers who live in Hamilton County.

frequently among Blacks than among Whites throughout the 1990's. In Hamilton County, Black infant mortality was 2 to 3 times more frequent among Blacks.

Infant mortality rates are higher among low birth weight infants. From 1991 to 2000, the proportion of White low birth weight infants in TN increased from 6.6 to 7.8 percent of all live births; in Hamilton County the percent of White low birth weight infants almost doubled (Table 4). Black low birth weight infants have remained fairly consistent throughout the decade at the state level but have been increasing in Hamilton County since 1997. In 2000, a Black mother in Hamilton County was twice as likely to have a low birth weight infant as a White mother, mirroring national trends.[27]

Table 4
Percent Low Birth Weight Infants
Hamilton County, TN and US 1991 - 2000



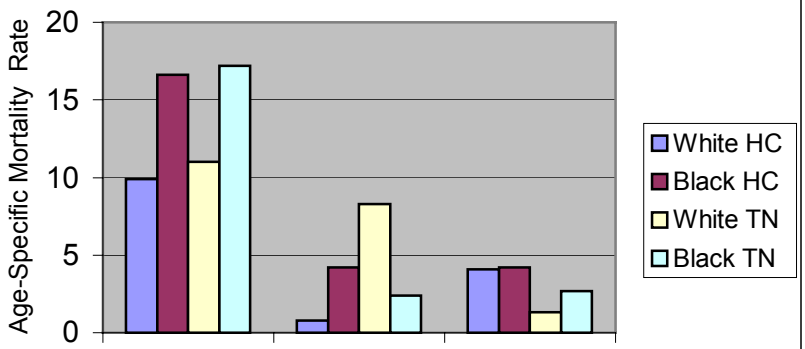
Source: TN Department of Health, CDC

[27] Nationally in the year 2000, Black low birth weight infants represented 13.0 % of all live births; White low birth weight infants represented 6.5% of all live births. Source: *MMWR,* op. cit.

CHILDREN

Leading causes of death for children ages 1 – 14 are shown for Hamilton County[28] and TN by race for 1998 – 2000 in Table 5 below.

Table 5
Leading Causes of Death for Children
Ages 1 - 14 in Hamilton County (HC) and TN
by Race Annualized Rates for 1998 - 2000



Source: TN Department of Health

Table 5 shows that accidents are the leading cause of death for children in Hamilton County and Tennessee as a whole. Black children in Hamilton county have a higher mortality rate from accidents than White children and the same disparity is found at the state level. Cancer was the second leading cause of death; however, total deaths from cancer in this age group are small (an average of 33 statewide).

[28] All mortality data throughout this document represent resident data: all decedents were living in Hamilton County. Residents of other counties who died in hospitals in Hamilton County are excluded from these reports.

Other important data concerning the health of children follow:

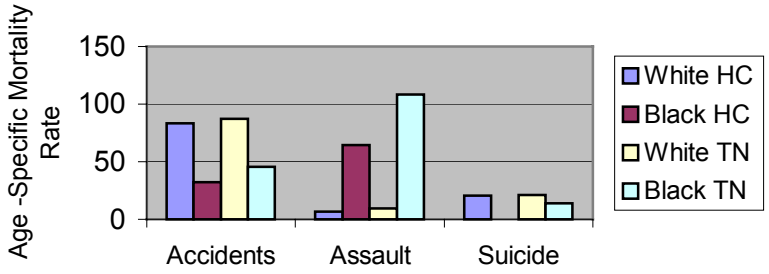
- In 1999, there were 26 reported pregnancies among girls ages 10 – 14 in Hamilton County[29]. The pregnancy rate per 1000 population was 1.1 for Whites and 6.9 for Blacks.
- In 2001, 86% of all children in Hamilton County were fully immunized by age 2,[30] close to the statewide average of 87% and the national goal of 90% as well.
- There were 517 cases of substantiated child abuse in Hamilton County in 1999[31]. These cases represent 7.3% of all children in the county, up from a rate of 6.5 the previous year.
- Poor children in Hamilton County scored significantly lower than other public school students in the county on state achievement scores. Among the nonpoor, the average 3rd grade reading scores on the TCAP[32] was 67; among the poor in the county the average was 35.
- About 18% of all children under age 6 in Hamilton County were enrolled in the Women, Infant and Children program in 2000. WIC data for these children showed that 15% of these children were overweight for height and an additional 7% were underweight for height. 4% suffered from low iron.

[29] Source: TN Department of Health
[30] In 1983, only 41.1% of all two year olds had completed their immunization series, compared with 86.3% in 2001. (Data from the Hamilton County Health Department.)
[31] ***Kids Count 2001***, TN Commission on Children and Youth
[32] Tennessee Comprehensive Assessment Program, State Dep't of Education, 2002

Young MEN Ages 15 – 24

Leading causes of death for men ages 15 – 24 in Hamilton County and Tennessee are shown by race in Table 6 below. Accidents are the leading cause of death for young White males; assaults (homicides) form the leading cause of death for young Black males.

Table 6
Leading Causes of Death for Men
ages 15 - 24 in Hamilton County (HC) and TN
by Race Annualized Rates 1998 - 2000



Source: TN Department of Health

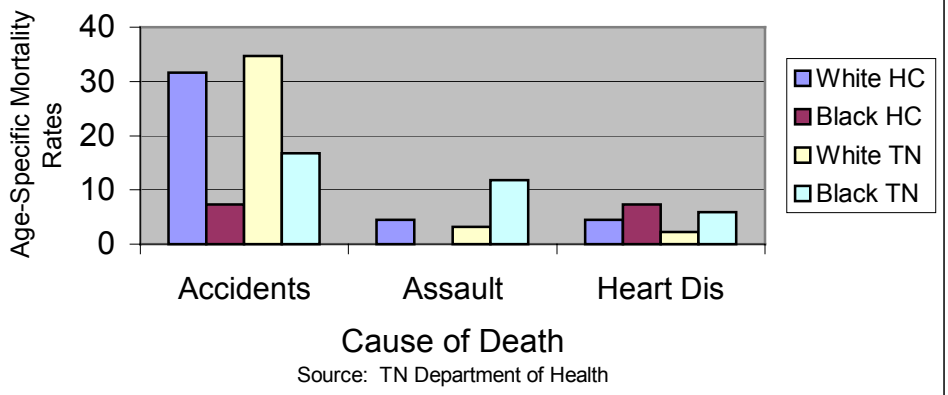
Other information about young adults (male and female) includes:

- About 12% of those entering high school in 1996 had dropped out before the typical graduation date of 2000, down from a rate of 16% from the 1995 school cohort.
- There were 3,353 juvenile court referral in 1999, or 4.7% of all youth under 18. Juvenile court referrals were down from 3,718, or 5.2%, in 1998.

Young WOMEN Ages 15 - 24

Accidents were the leading cause of death for women age 15 – 24 in Hamilton County and Tennessee (Table 7).

Table 7
Leading Causes of Death for Women Ages 15 - 24
by Race in Hamilton County (HC) and TN
Annualized Rates 1998 - 2000



Source: TN Department of Health

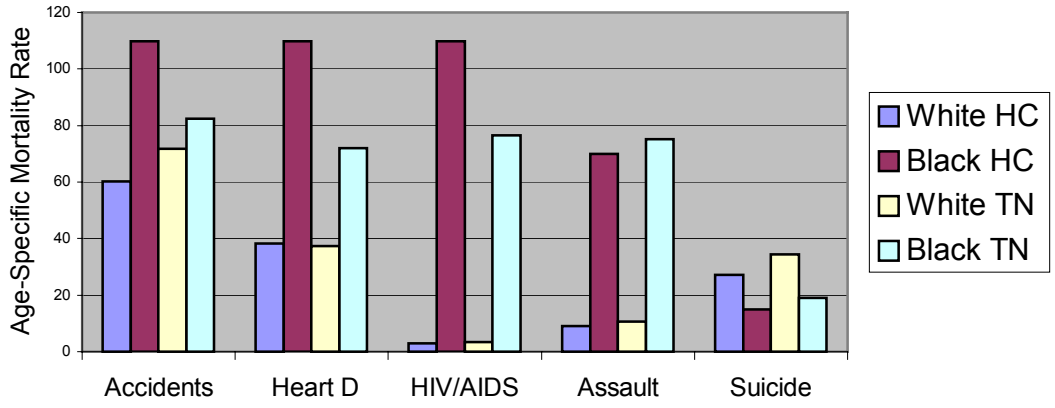
Other important health data for young women follow:

- In the 1990's, adolescent pregnancies decreased from a rate of 27.3 per thousand women (ages 10-17) to a low of 15.0 in 1998. Since that time, however, rates have been increasing and by 2001 the rate was up to 16.7.
- The low birth weight rate was 15.3 per thousand live births among Black women ages 15 – 19; among Whites the rate was 9.8.
- About 1 in 10 Black women ages 15 – 19 tested positive for chlamydia in 2000.

MEN Ages 25 – 44

Accidents, Heart Disease and AIDS form the three leading causes of death for Black men ages 25 – 44 in Hamilton County (Table 8). Mortality rates from these 3 causes were significantly higher than statewide rates among Black men; and within the county, the disparity between Black and White mortality rates were large.

Table 8
Leading Causes of Death for Men Ages 25 - 44
Hamilton County (HC) and TN Annualized Rates 1998 - 2000



Source: TN Department of Health

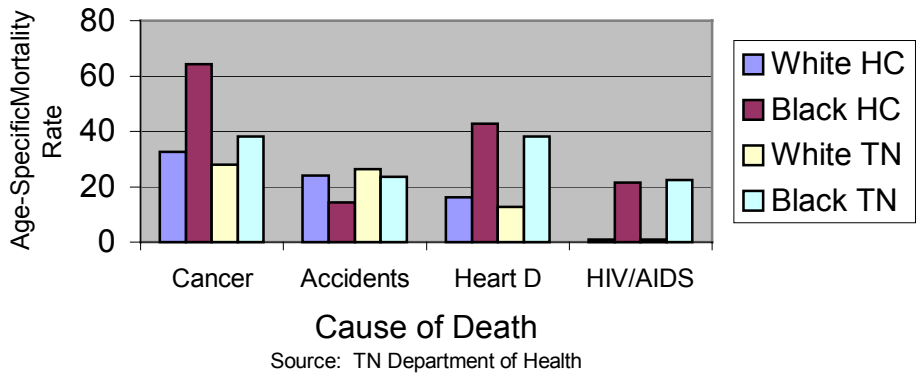
Although deaths from HIV/AIDS have been dramatically reduced over the last few years, new cases of AIDS are increasing. By the end of July 2002, more new cases of AIDS had been reported than in all of 2001[33].

[33] Source: Chattanooga-Hamilton County Health Department AIDS Outreach

WOMEN Ages 25 – 44

Cancer was the leading cause of death for women ages 25 – 44 in both the county and the state (Table 9). The rate of deaths from cancer for Black women in Hamilton County was double the rate for Whites in the County and also significantly higher than for Blacks throughout the state. Heart Disease and AIDS were the second and third leading causes of death for Black women in the county; accidents and heart disease were second and third for White women.

Table 9
Leading Causes of Death for Women 25 - 44 Hamilton County (HC) and TN by Race
Annualized Rates 1998 - 2000



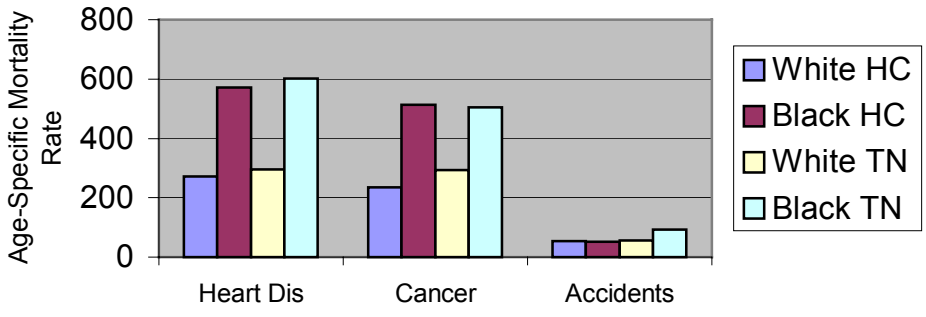
Source: TN Department of Health

A review of mortality data shows that the rate of death from cancer generally increased during the 1990's among this age group of women, from a low of 23.6 deaths per thousand in 1991 to a high of 51.0 deaths per thousand in 1999, although rates dropped again in 2000.

MEN Ages 45 – 64

Heart Disease and Cancer were the leading causes of death for men ages 45 – 64 (Table 10). Black men in this age group were about twice as likely to die from heart disease and cancer as White men.

Table 10
Leading Causes of Death for Men 45 - 64 in Hamilton County (HC) and TN by Race Annualized 1998 - 2000



Source: TN Department of Health

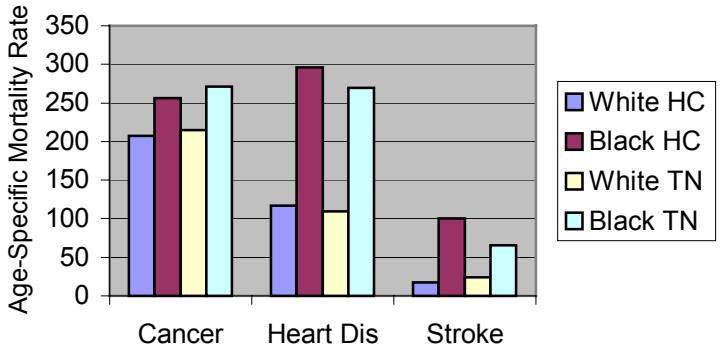
Other causes of death included

- For White men, the 4th and 5th leading causes of death were chronic lower respiratory disease, and chronic liver disease and cirrhosis.
- For Black men the 4th and 5th causes were stroke and diabetes.

WOMEN Ages 45 – 64

Cancer and Heart Disease were the two leading causes of death for women ages 45 – 64 (Table 11). For Black women in Hamilton County, heart disease was the number one killer, with cancer a close second. For White women, cancer was the leading cause of death, with heart disease following at about half the rate of cancer. Black women were almost 3 times as likely to die from heart disease as White women in the county.

Table 11
Leading Causes of Death for Women
45 - 64 in Hamilton County (HC) and TN
by Race Annualized 1998 - 2000



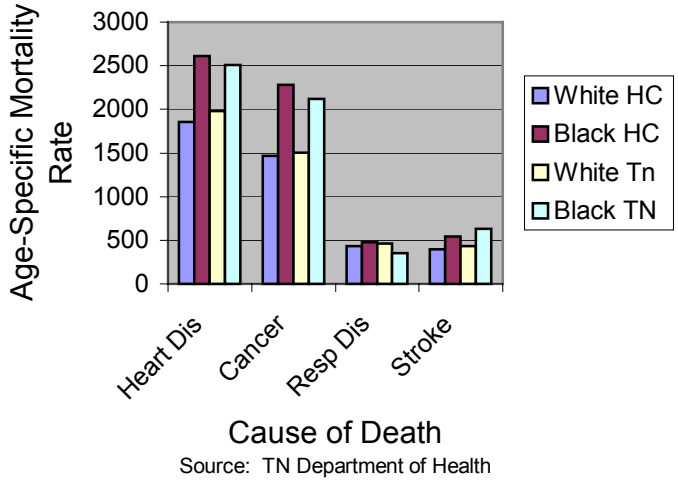
Source: TN Department of Health

Also appearing as the 4th and 5th leading causes of death (not shown above) were chronic lower respiratory disease and diabetes.

MEN Ages 65 and above

Leading causes of death for men ages 65 and older were heart disease and cancer (Table 12).

Table 12
Leading Causes of Death for Men 65 +
Hamilton County (HC) and TN by Race
Annualized Rates 1998 - 2000



Source: TN Department of Health

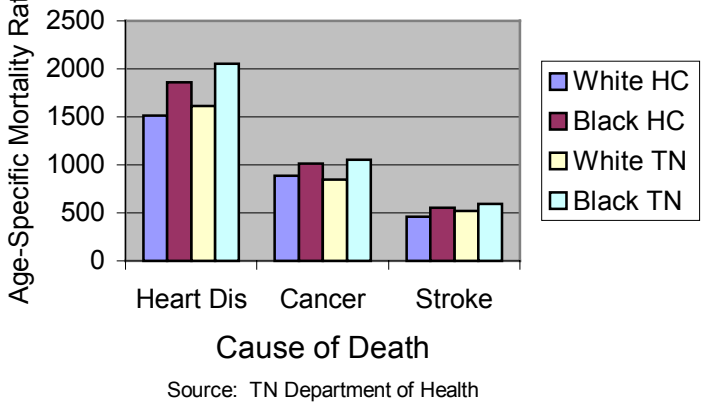
Other leading causes of death included:

- Diabetes, which ranked as the 5th leading cause of death for Black men ages 65 and over and the 6th leading cause for Whites.
- Alzheimer's Disease, which ranked as the 8th leading cause of death among White men.
- Atherosclerosis, which ranked as the 8th leading cause of death among men in Hamilton county at a rate over 4 times that of the state as a whole.

WOMEN Ages 65 and older

Leading causes of death for women ages 65 and older were heart disease, cancer and stroke.

Table 13
Leading Causes of Death for Women
65 + in Hamilton County (HC) and TN
by Race Annualized Rates 1998 - 2000



Source: TN Department of Health

Other leading causes of death included:

- Diabetes, which ranked as the 4th leading cause of death for Black women in this age group and the 8th for Whites.
- Alzheimer's Disease, which ranked as the 5th leading cause of death for White women and the 6th for Black women in Hamilton County.
- Atherosclerosis, which ranked as the 6th leading cause of death among White women at a rate over 3 times higher than the state as a whole.

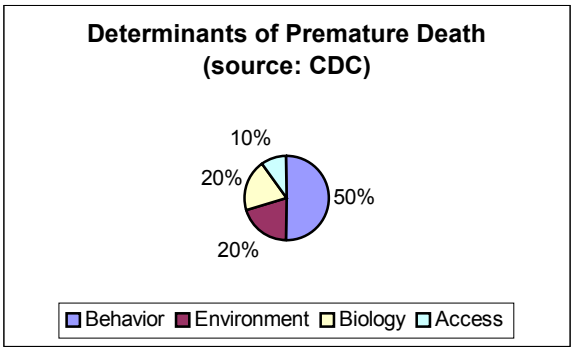
Key Findings

Key findings from the review of mortality and related data include:

- Infant mortality, while declining about 25% nationally over the last decade, has been increasing in Hamilton County.
- Although the proportion of low birth weight infants has remained about the same for Black nationally and increased slightly for Whites, in Hamilton County the same figures have doubled for the White population and increased about 20% for the Black population.
- Heart disease, the leading cause of death both nationally and locally, is significantly higher in Hamilton County than in the nation as a whole. Blacks are one and one half times as likely to die from heart disease in the county than Blacks nationally; Whites are about one and one third as likely to die from heart disease as Whites nationally.
- The disparity between mortality rates for Blacks and Whites is high. In age and sex group specific data, Black mortality rates are often more than twice the White rates.

Individual health behaviors, physical, economic, and social environmental factors, as well as important health systems issues greatly impact mortality. Some estimates suggest that about half of all premature deaths are related to health behaviors (Chart 8).

Chart 8



Leading Health Indicators

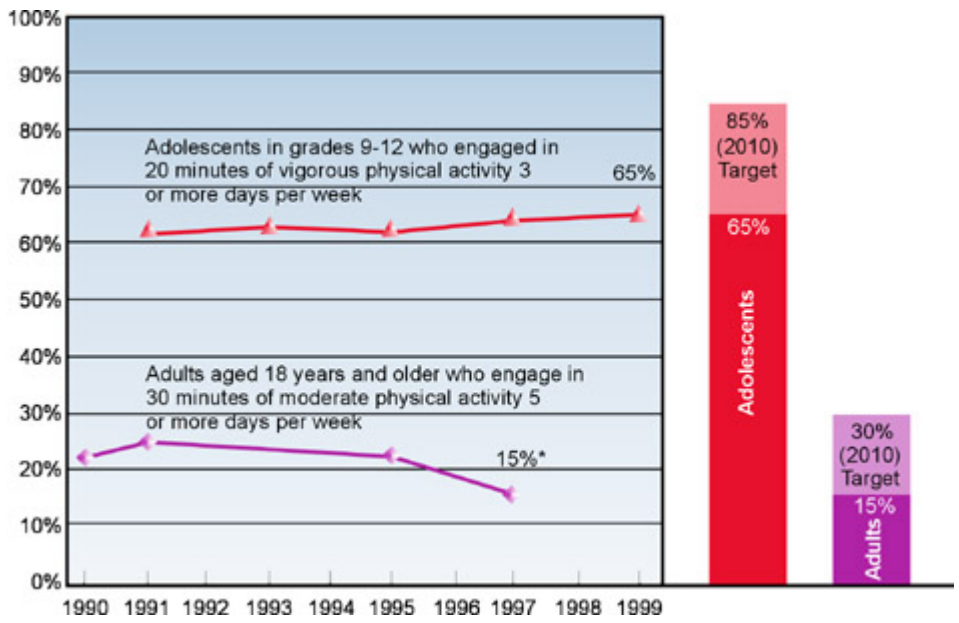
The national campaign **Health People 2010** developed ten leading health indicators designed to illuminate and measure the underlying factors contributing to premature deaths.

- Physical activity
- Overweight and obesity
- Tobacco use
- Substance abuse
- Responsible sexual behavior
- Mental health
- Injury and violence
- Environmental quality
- Immunization
- Access to health care

Physical Activity[34]

Regular physical activity throughout life is important for maintaining a healthy body, enhancing psychological well-being, and preventing premature death. In 1999, 65 percent of adolescents engaged in the recommended amount of physical activity. In 1997, only 15 percent of adults performed the recommended amount of physical activity, and 40 percent of adults engaged in no leisure-time activity.

Participation in regular physical activity, United States, 1990–99

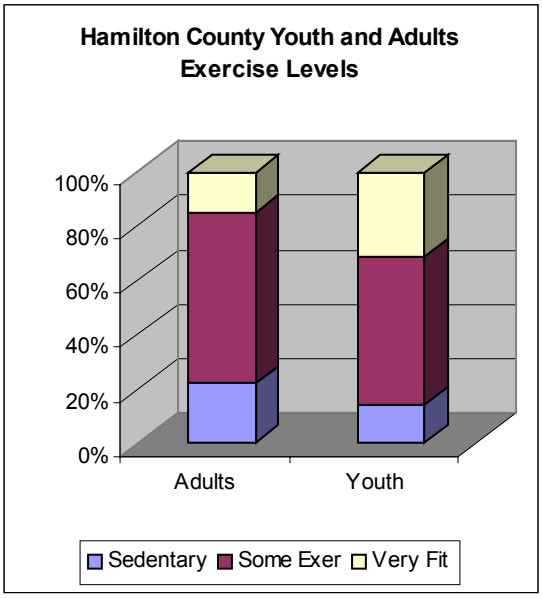


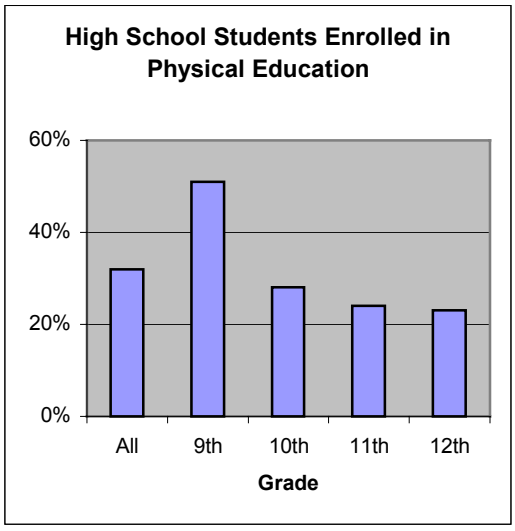
*The definition of moderate physical activity was changed in 1997.

Sources: Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System. 1991–97. Centers for Disease Control and Prevention, National Center for Health Statistics. National Health Interview Survey. 1990–99.

[34] Excerpted from ***Healthy People 2010, I, 28*** as modified at www.health.gov/healthypeople/

Physical Activity* in Hamilton County





* All data are taken from the BRFSS (1999) and the YBRFSS (1998).

Physical Activity

- 15% of adults and 31% of youth may be classified as "very fit," engaging in all of the following each week: 3 or more aerobic workouts, 2 or more strengthening workouts, and 3 or more sessions of stretching exercises. An additional 63% of adults and 55% of youth engage in lesser amounts of exercise.
- 45% of youth reported 3 or more sessions of vigorous physical activity 3 or more times per week.
- 22% of adults and 14% of youth are "sedentary," not engaging in any exercise in a typical week.
- Overall, males are more active than females.

Physical Education and Sports

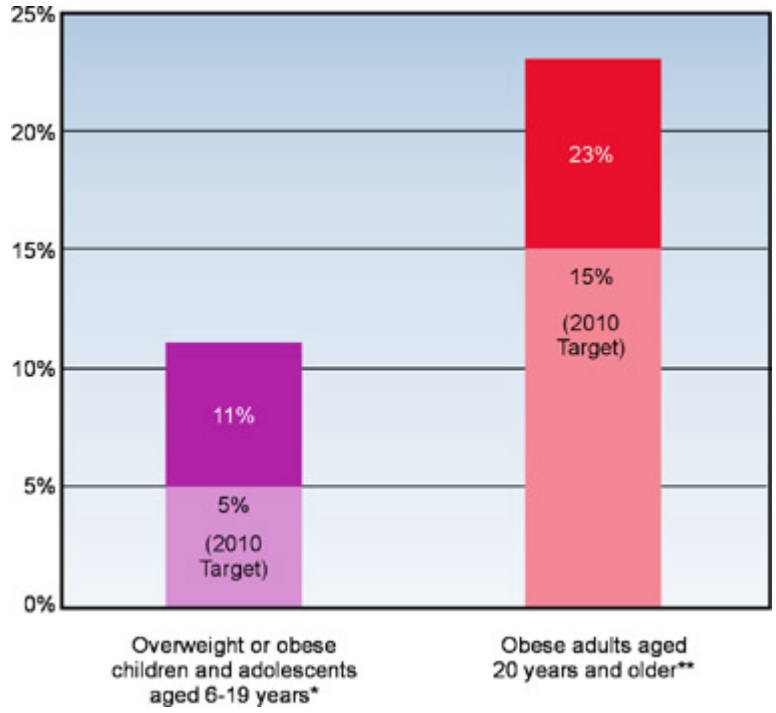
- Only 32% of Hamilton County high school students are enrolled in Physical education classes. An additional 20% of students who are not enrolled in physical education participate in team sports.
- Physical education participation is highest in the ninth grade (51%) falling to about 25% in other grades.
- Among students enrolled in physical education, 41% spend less that 30 minutes actually exercising or playing sports.

Overweight and Obesity[35]

Overweight and obesity are major contributors to many preventable causes of death. On average, higher body weights are associated with higher death rates. The number of overweight children, adolescents, and adults has risen over the past four decades. Total costs (medical cost and lost productivity) attributable to obesity alone amounted to an estimated $99 billion in 1995.

During 1988–94, 11 percent of children and adolescents aged 6 to 19 years were overweight or obese. During the same years, 23 percent of adults aged 20 years and older were considered obese.

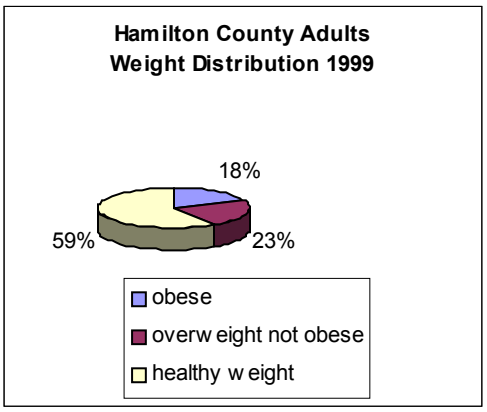
Overweight and obesity, United States, 1988–94



Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Health and Nutrition Examination Survey. 1988–94.

[35] This page excerpted from ***Healthy People 2010*** Volume 1 page 28

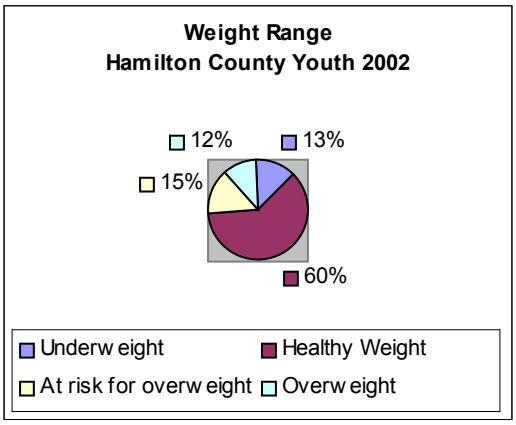
Overweight and Obesity in Hamilton County



Source: BRFSS 1999

Adult Overweight and Obese

- Almost one in five adults in Hamilton County is obese; two in five are overweight or obese.
- Poor women are more likely to be overweight or obese than middle to upper income women. Extreme obesity is over twice as common in the lower income population.
- Among pregnant women[36] on the Women, Infants and Children program, 37% were certified with a nutritional risk of prepregnancy overweight. An additional 16% had low iron.



Source: YBFRSS 2002

Youth Overweight and Obese

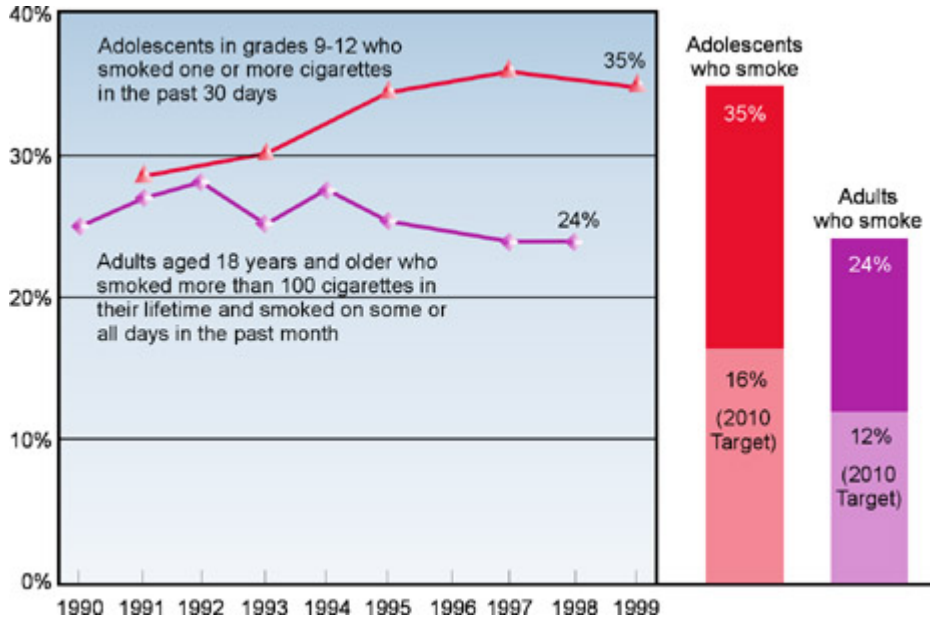
- Self-reported weight for Hamilton County youth showed about 60% at a healthy weight.
- About 45% of all young people reported that they are trying to lose weight.
- Females were twice as likely as males to report efforts at weight loss.

[36] About half of all pregnant women in Hamilton County receive WIC services.

Tobacco Use[37]

Cigarette smoking is the single most preventable cause of disease and death in the United States. Smoking results in more deaths each year in the United States than AIDS, alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires—combined. Tobacco-related deaths number more than 430,000 per year among U.S. adults, representing more than 5 million years of potential life lost. Direct medical costs attributable to smoking total at least $50 billion per year. In 1999, 35 percent of adolescents were current cigarette smokers. In 1998, 24 percent of adults were current cigarette smokers.

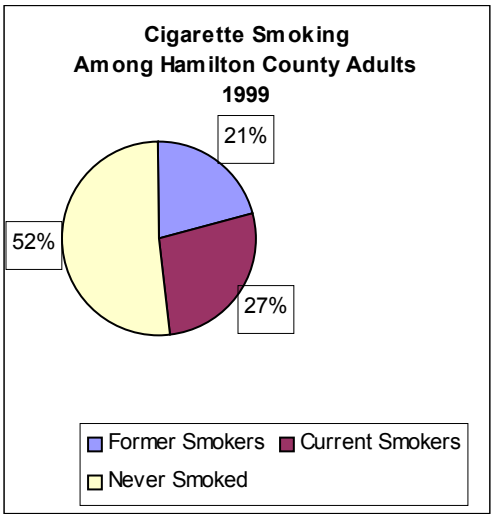
Cigarette smoking, United States, 1990–99



Sources: Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System. 1991–99. Centers for Disease Control and Prevention, NCHS Survey 1990–98.

[37] Excerpted from ***Healthy People 2010***, 1, 30 as updated at www.health.gov/healthypeople/

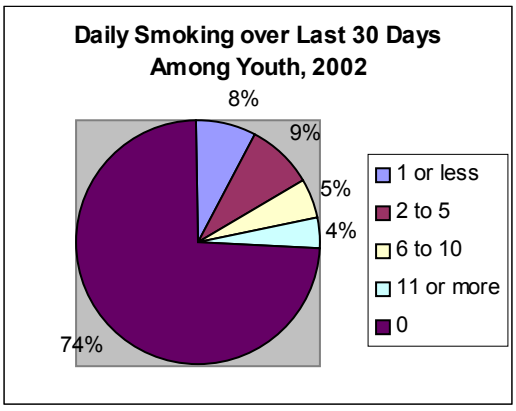
Tobacco Use* in Hamilton County



Source: BFRSS 1999

Adult Smoking Behaviors

- 27% of adults in Hamilton County are smokers. Among smokers, one in five smokes a pack a day or more.
- About 32% of men and 23% of women were current smokers.
- The lower the income, the more likely a person is to smoke. Almost 40% of those with incomes of under $15,000 were current smokers.
- Among current smokers, over 70% reported that they would like to quit.
- The 45 – 54 age group was the most likely to smoke (almost 40%). 90% of adult smokers started as teenagers.



Source: YBRFSS 2002

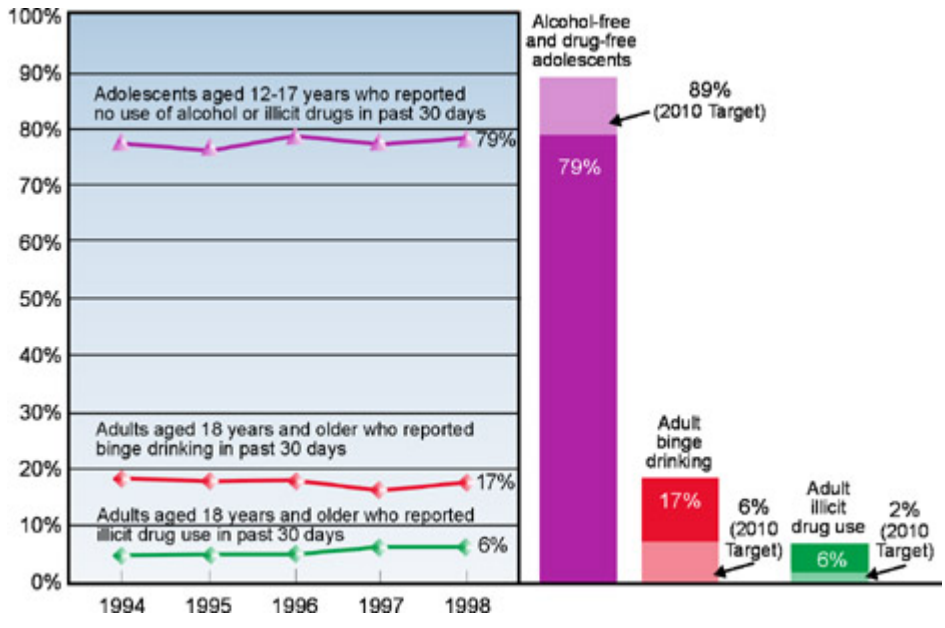
Youth smoking behaviors

- 74% of high school youth have not smoked in the last 30 days.
- Among students who smoke, 60% report having tried to quit.
- White students are more likely to smoke than Black students, and much more likely to be daily smokers.
- Almost half of all youth who had ever tried smoking did so before the age of thirteen.

Substance Abuse[38]

Alcohol and illicit drug use are associated with many of this country's most serious problems, including violence, injury, and HIV infection. The annual economic costs to the United States from alcohol abuse were estimated to be $167 billion in 1995, and the costs from drug abuse were estimated to be $110 billion. In 1998, 79 percent of adolescents aged 12 to 17 years reported that they did *not* use alcohol or illicit drugs in the past month. In the same year, 6 percent of adults aged 18 years and older reported using illicit drugs in the past month; 17 percent reported binge drinking in the past month, (consuming five or more drinks on one occasion).

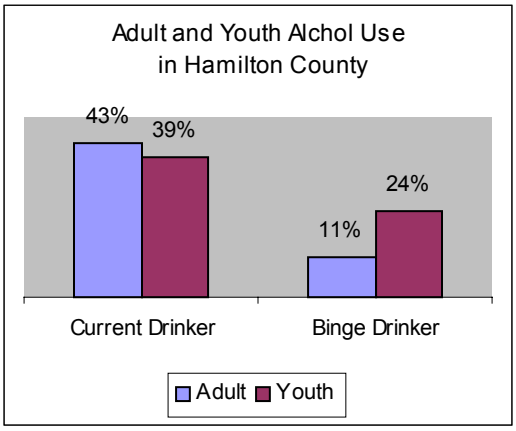
Use of alcohol and/or illicit drugs, United States, 1994–98



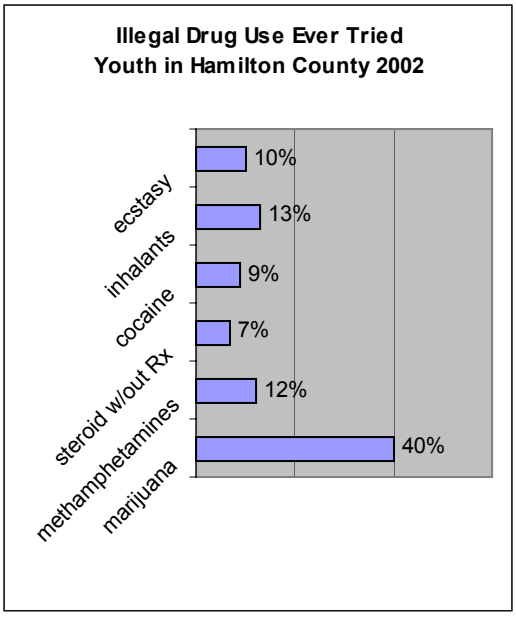
Source: Substance Abuse and Mental Health Services Administration, Office of the Assistant Secretary. National Household Survey on Drug Abuse. 1994–98.

[38] Excerpted from ***Healthy People 2010***, 1, 32, as updated at www.health.gov/healthypeople/

Substance Abuse in Hamilton County



Source: BRFSS 1999, YBRFSS 2002



Source: YBRFSS 2002

Alcohol Use in Hamilton County

- Among adults in Hamilton County, 43% reported having a drink within the last 30 days. 39% of high school youth also reported recent drinking.
- Among youth, 24% reported a recent episode of binge drinking, versus 11% of adults.
- About 12% of youth and 2% of adults admitted to driving while drinking in the last 30 days. 27% of youth had been in a vehicle driven by someone who had been drinking.

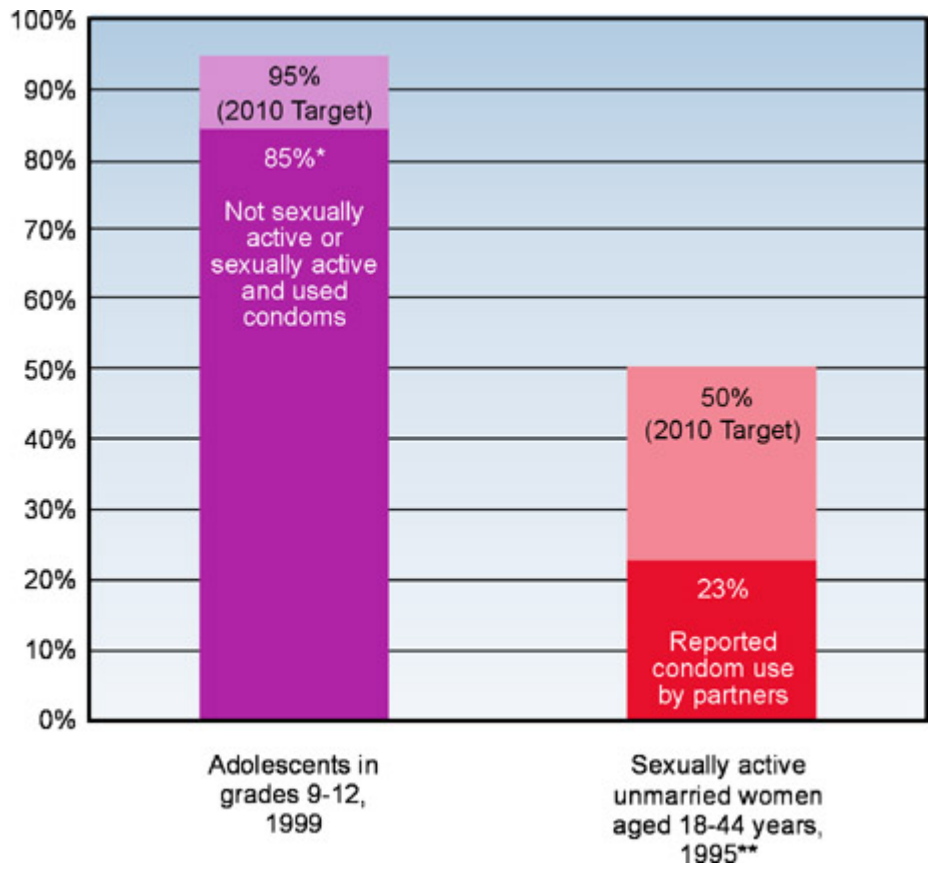
Illegal Drug Use Among Youth

- Among Hamilton County High School youth, 40% have tried marijuana and 23% report using marijuana in the last 30 days.
- One in four of those who have tried marijuana were under the age of fourteen at first exposure.
- 28% of students report being offered, sold or given an illegal drug on school property.

Responsible Sexual Behavior[39]

Unintended pregnancies and sexually transmitted diseases (STDs), including infection with the human immunodeficiency virus that causes AIDS, can result from unprotected sexual behaviors. Abstinence is the only method of complete protection. Condoms, if used correctly and consistently, can help prevent both unintended pregnancy and STDs.

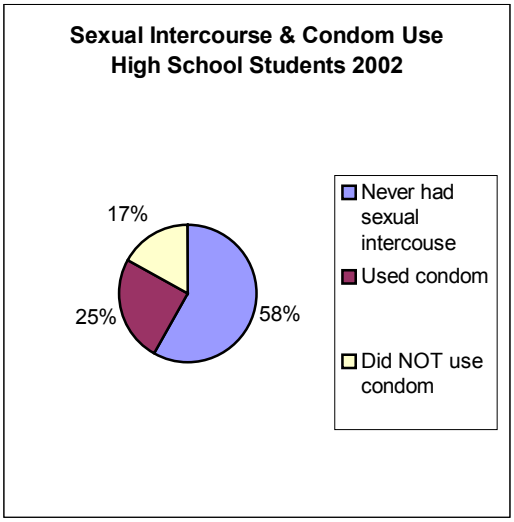
Responsible sexual behavior, United States, 1995 and 1999



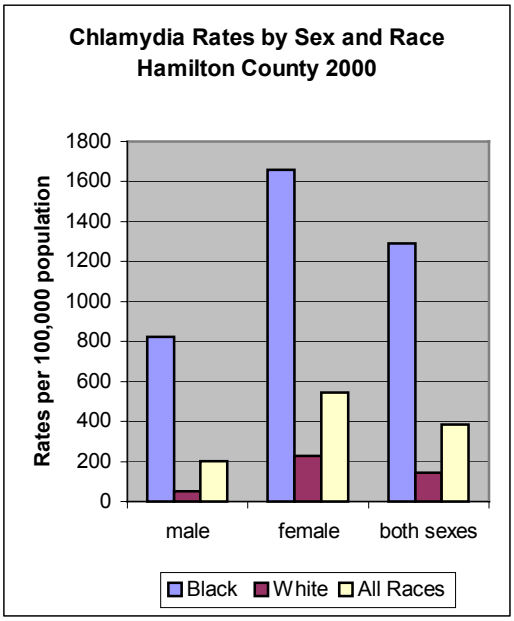
Sources: Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System. 1999. Centers for Disease Control and Prevention, National Center for Health Statistics. National Survey of Family Growth. 1995.

[39] Excerpted from Health People 2010, 1, 34, as updated at www.health.gov/healthypeople/

Risky Sexual Behavior in Hamilton County



Source: YBRFSS 2002



Source: Tennessee Dep't of Health[40]

[40] Chlamydia is a sexually transmitted disease, often asymptomatic. Up to 40% of women with untreated chlamydia will develop Pelvic Inflammatory Disease and 20% of those will become infertile.
Source: www.cdc.gov

Sexual Behavior

- Among Hamilton County High School students in 2002, 58% reported never having had sex. Another 25% reported using a condom during the most recent sexual intercourse.
- Most students (69%) reported that they did not consider oral sex as "having sex." 45% reported participating in oral sex.
- 20% of youth reported sexual intercourse with 3 or more partners. 45% of Adults who reported 3 or more partners in the last year used condoms.

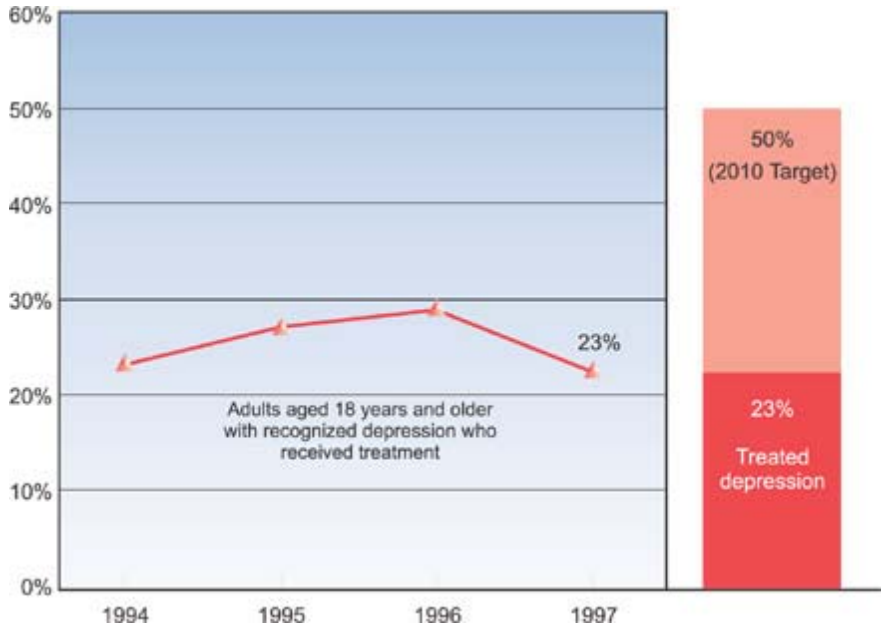
STD's and HIV/AIDS

- Rates of STD's and newly reported cases of AIDS are up in the county.
- The rate of chlamydia in Hamilton County in 2000 was 384 per 100,000, compared to a statewide rate of 259.
- The highest rate of chlamydia was among women ages 15 – 19, representing 31% of all cases. The rate for Black women was eight times the rate for White women.
- In 1999, the total reported new AIDS cases was 54; by the end of July 2002, reported new cases was already at 64.

Mental Health[41]

Approximately 20 percent of the U.S. population is affected by mental illness during a given year; no one is immune. Of all mental illnesses, depression is the most common disorder. More than 19 million adults in the United States suffer from depression. Major depression is the leading cause of disability and is the cause of more than two-thirds of suicides each year. In 1997, only 23 percent of adults diagnosed with depression received treatment.

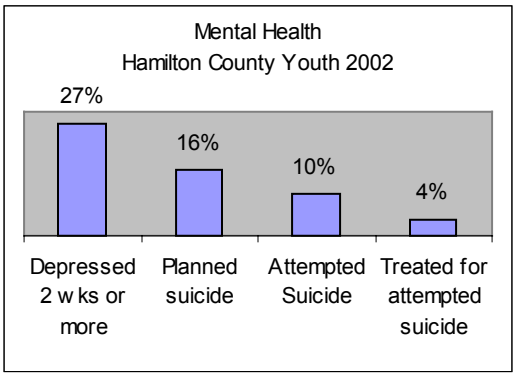
Adults with depression* who received treatment, United States, 1994–97**



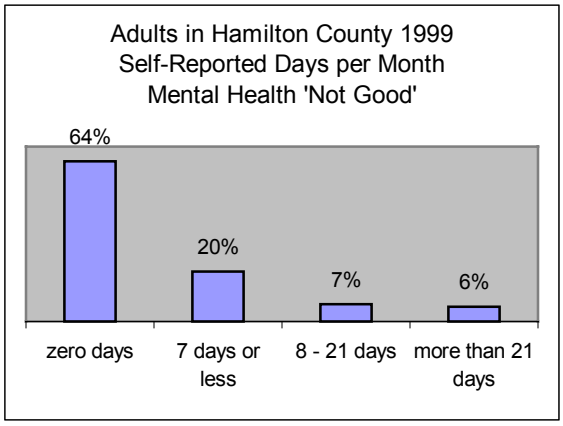
Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. National Household Survey on Drug Abuse. 1994–97.

[41] This page excerpted from Health People 2010, Volume 1, page 36

MENTAL HEALTH in Hamilton County



Source: YBRFSS 2002



Source: BRFSS 1999

Youth Mental Health

- About one in four high school youth in Hamilton County reported feeling sad or hopeless for two or more weeks to the extent that some usual activities were stopped
- Over 60% of the youth reported that they were trying to gain or lose weight.
- 15% reported planning a suicide and 10% reported a suicidal attempt. Suicide was the 2nd leading cause of death for White men ages 15 – 24.

Adults and Mental Health

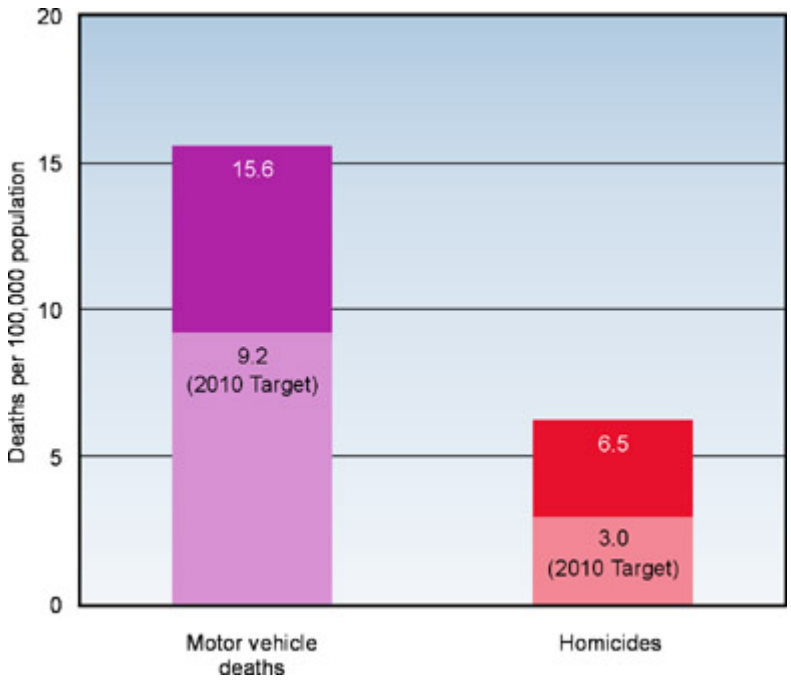
- About 13% of Hamilton County Adults described their mental health as "not good" for more than one week of the month. An additional 20% reported poor mental health one week or less.
- Suicide was the 10th leading cause of death for Whites in Hamilton County, and the third leading cause for White men ages 25 – 44.
- Studies show that depression is particularly common in late life[42]. Estimates are that only one in ten depressed elderly person receives treatment.

[42] source: AARP

Injury and Violence[43]

More than 400 Americans die each day from injuries due primarily to motor vehicle crashes, firearms, poisonings, suffocation, falls, fires, and drowning. The risk of injury is so great that most persons sustain a significant injury at some time during their lives. Motor vehicle crashes are the most common cause of serious injury. In 1998, there were 15.6 deaths from motor vehicle crashes per 100,000 persons. Because no other crime is measured as accurately and precisely, homicide is a reliable indicator of all violent crime. In 1998, the murder rate in the United States fell to its lowest level in three decades—6.5 homicides per 100,000 persons.

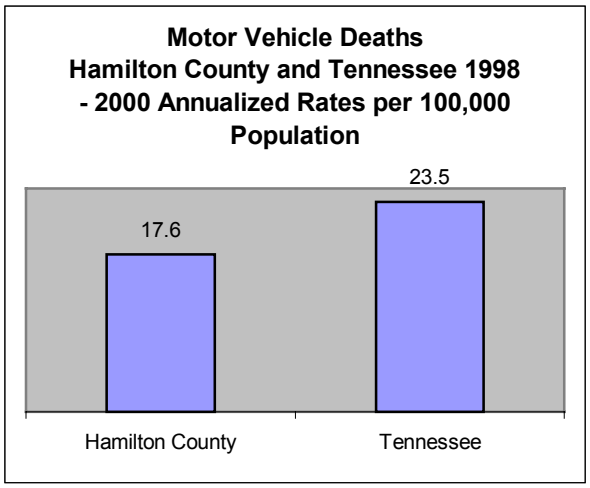
Motor vehicle deaths and homicides, United States, 1998



Source: CDC, NCHS. National Vital Statistics System. 1998.

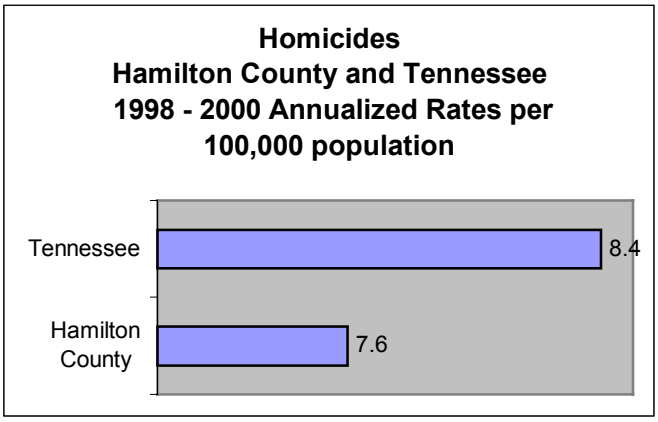
[43] Excerpted from **Healthy People 2010**, 1, 38, as updated at www.health.gov/healthypeople/

Injury and Violence in Hamilton County



Motor Vehicle Accidents

- Four out of ten motor vehicle accidents with injury were alcohol related.
- Current seat belt use in Hamilton County is about 60%. Among pick-up truck drivers, the rate falls to 30%.
- Information from Erlanger Medical Center (and its Level 1 Trauma Unit) shows that among injured teenage patients hospitalized for a car accident, only 19% were wearing a seatbelt at the time of collision.



Violence

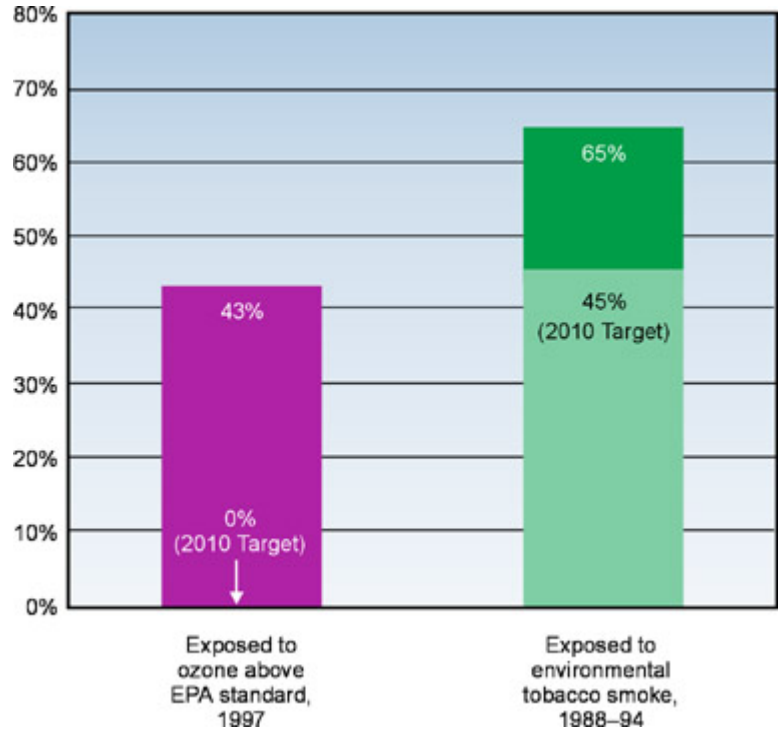
- Homicide rates have generally decreased at the state and county level over the last decade.
- Domestic Violence was involved in 38% of the homicides in Hamilton County in 2001.[44]
- Among high school students, 11% reported being physically forced to have sexual intercourse. Comparable national data shows a national rate of 7.7%.[45]

[44] Source: The Coalition Against Domestic and Community Violence of Greater Chattanooga.
[45] YBFRSS, Hamilton County 2002, Nationwide, 2001

Environmental Quality[46]

An estimated 25 percent of preventable illnesses worldwide can be attributed to poor environmental quality. In the United States, air pollution alone is estimated to be associated with 50,000 premature deaths and an estimated $40 billion to $50 billion in health-related costs annually.

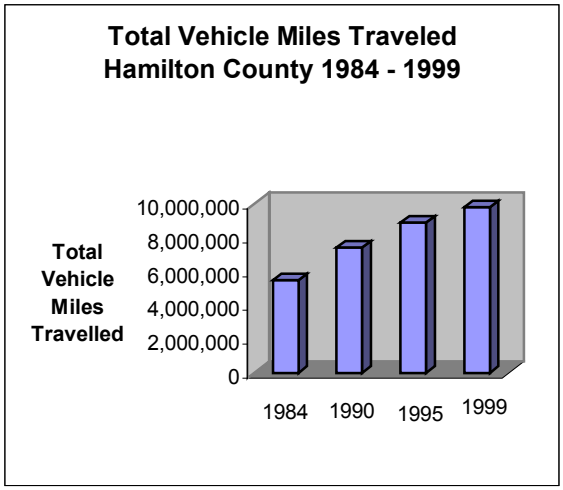
Ozone and environmental tobacco smoke exposure, United States, 1988–94 and 1997



Sources: U.S. Environmental Protection Agency. Aerometric Information Retrieval System. 1997. Centers for Disease Control and Prevention, National Center for Health Statistics. National Health and Nutrition Examination Survey. 1988–94.

[46] This page excerpted from ***Healthy People 2010***, Volume 1, page 40.

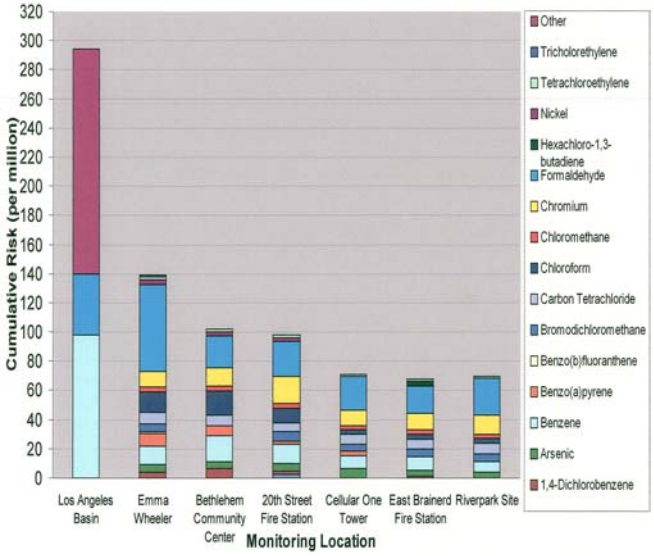
Environmental Quality in Hamilton County



Air Quality Parameters[47]

- Air Quality in Chattanooga has met all federal standards since 1989, but new federal standards for ozone and fine particulates may not be achieved.
- Air emissions from industrial sites have decreased in Hamilton County over the last decade. During the same time period, however, vehicle emissions have greatly increased.
- The number of vehicle miles traveled has almost doubled in Hamilton County since the mid-1980's.
- Other pollutants are released directly from natural sources. Pollen counts in the county are in the Extremely Heavy range in the Spring and Fall.

Lifetime Cancer Risks



Health Effects of Air Quality

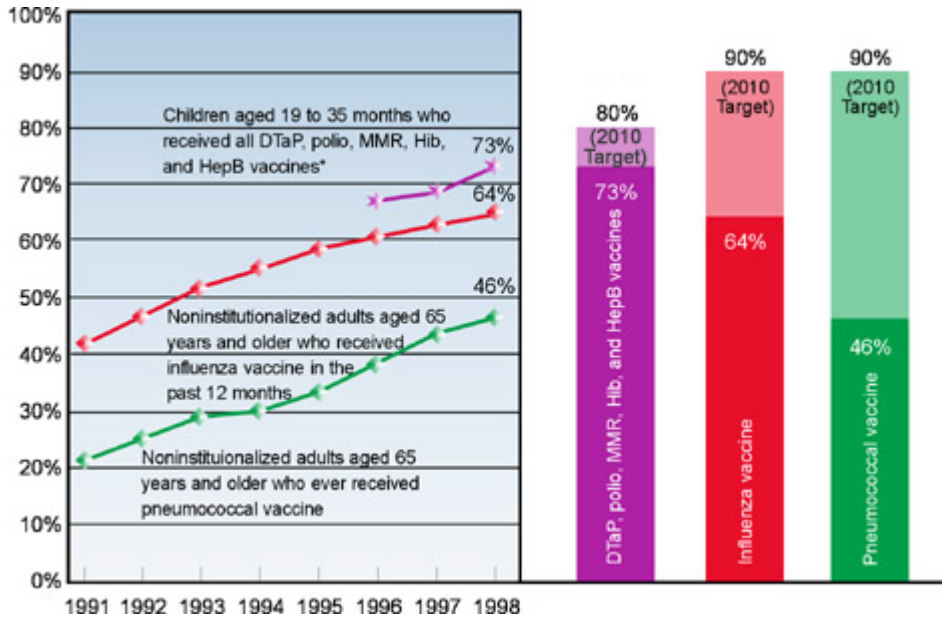
- Chattanooga participated in a pilot air toxic study sources to assess cancer and non-cancer health risks.
- The study showed a local risk of getting cancer from air pollution of 70 to 100 times more than the "acceptable" goal.
- Estimates are that 90% of added cancer risk and 69% of adverse non-cancer effects in the county are from mobile sources (cars, trucks, and buses.)

[47] Source: The Air Pollution Control Board, Chattanooga.

Immunization[48]

Vaccines are among the greatest public health achievements of the 20th century. Immunizations can prevent disability and death from infectious diseases for individuals and can help control the spread of infections within communities. In 1998, 73 percent of children received all vaccines recommended for universal administration. In 1998, influenza immunization rates were 64 percent in adults aged 65 years and older—almost double the 1989 immunization rate of 33 percent. In 1998, only 46 percent of persons aged 65 years and older ever had received a pneumococcal vaccine.

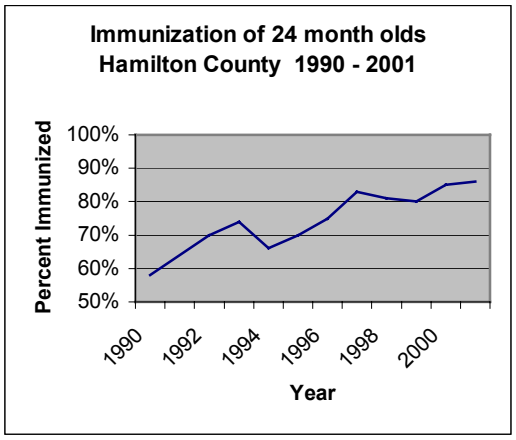
Immunization coverage, United States, 1991–98



Sources: Centers for Disease Control and Prevention, National Center for Health Statistics and National Immunization Program. National Immunization Survey. 1996–98. Centers for Disease Control and Prevention, National Center for Health Statistics. National Health Interview Survey. 1991–98.

[48] This page excerpted from *Healthy People 2010* Volume 1 page 42

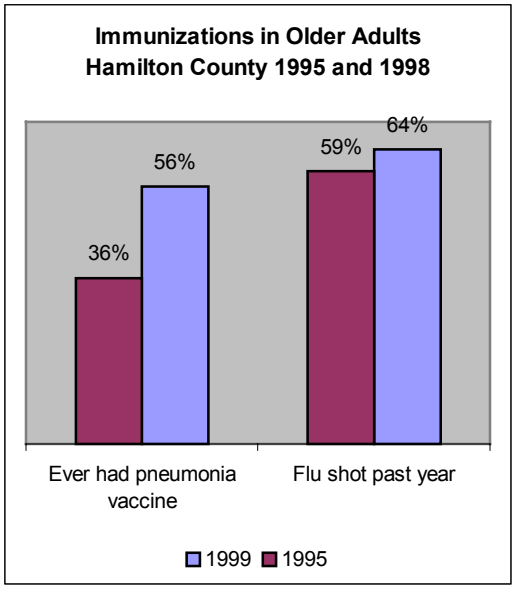
Immunizations in Hamilton County



Source: Chattanooga - Hamilton County Health Department's Immunization Outreach Program.

Childhood Immunizations

- 86% of all children in Hamilton County were fully immunized by age 2.
- The proportion of children fully immunized has doubled since 1990.
- Health professionals are expressing concern about a recent trend of parents who are choosing to decline to have their children immunized.



Source: BFRSS, see appendix B.

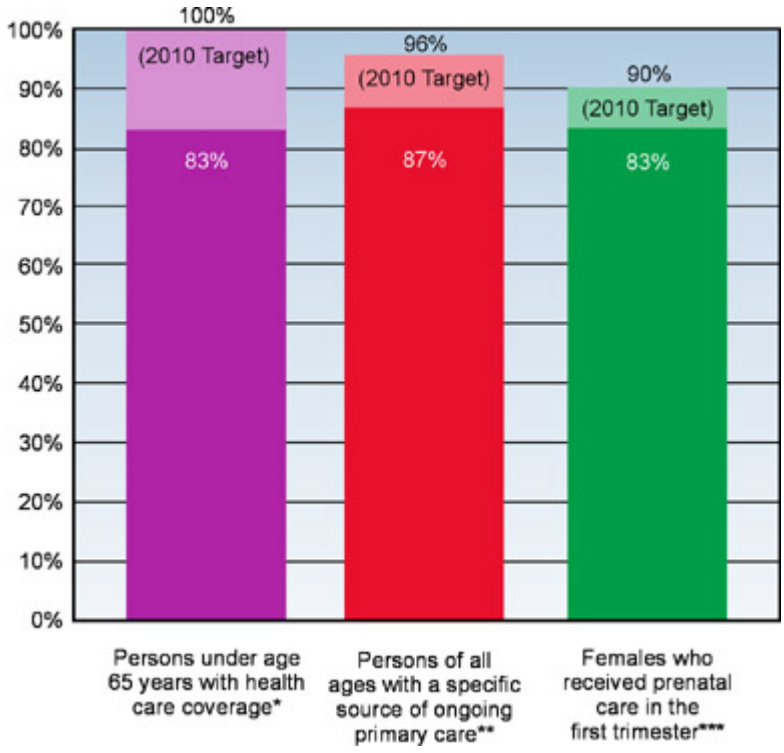
Adults and Immunizations

- The proportion of older adults receiving the pneumonia vaccine increased 20% from 1995 to 1998.
- In the overall adult population, Blacks were about 10% less likely than whites to have received either a pneumonia vaccine or a flu shot (not shown in table).

Access to Health Care[49]

Strong predictors of access to quality health care include having health insurance, a higher income level, and a regular primary care provider or other source of ongoing health care. Use of clinical preventive services, such as early prenatal care, can serve as indicators of access to quality health care services. In 1997, 83% of all persons under age 65 years had health insurance. In 1998, 87% of persons of all ages had a usual source of health care.

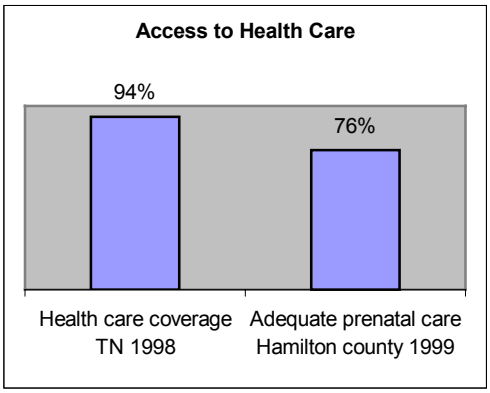
Access to health care, United States, 1997 and 1998



Sources: Centers for Disease Control and Prevention, NCHS. National Health Interview Survey. *1997 and **1998. Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System. ***1998.

[49] Excerpted from **Healthy People 2010,** 1, 44, as updated at www.health.gov/healthypeople/

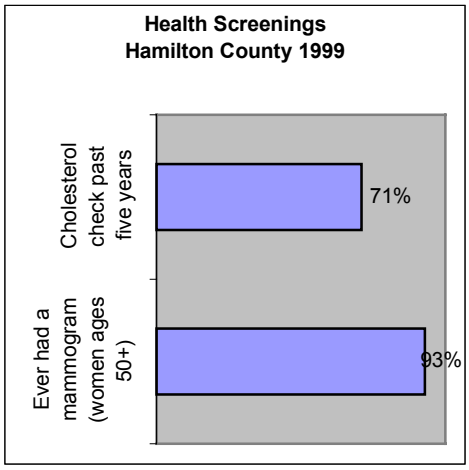
Access to Health Care in Hamilton County



Health care coverage source: The Center for Business and Economic Research, UTK. Adequate prenatal care source: TN Dep't of Health Vital Statistics (Kessner Index)

Health Care Coverage

- About 94% of all people in TN have health insurance.[50][51]
- Only 4% of those under 18 are uninsured. 7% of those 18 and over are uninsured.
- Tennessee spends less per person on its health care insurance program for poor, disabled and uninsured individuals than any program in the nation.[52]
- About 3 out of 4 pregnant women receive adequate prenatal care.



Source: BRFSS 1999.

Health Screenings

- Among women ages 50 and over, 93% reported having had a mammogram at some time.
- Among all adults, 71% had been screened for high cholesterol in the past five years.
- Blacks and Whites were about equally likely to have participated in screenings.

[50] Other estimates are in the 90% range, still high for the US.
[51] Current estimates of uninsured for Hamilton County alone are unavailable at this time.
[52] Centers for Medicare and Medicaid Services, 2002 report based on 1998 data.

Health Status Assessment
Implications for Future Directions
Regional Health Council
Findings and Future Directions

The Regional Health Council had begun discussion of the information contained in this document and is now considering possible future approaches. The discussion includes:

- A renewed sense of purpose: the health status of the people of Hamilton County is far less than its potential. The Council is uniquely positioned to focus the attention of the entire community on these concerns and to develop strategies to promote change.

- The need to develop cooperation and coordination between institutions, agencies and programs to emphasize a sense of community and maximize the use of limited resources.

- A particular concern for infant mortality and morbidity: the underlying picture of poor maternal health in the county may require further study and contact with other groups concerned. Low birth weight may be useful as the overall marker of the community's health.

- A continued focus on individual health behaviors: already addressed in the work of the five subcommittees. The Council may need to focus its efforts

on one or only several risky behaviors while providing a catalyst for other organizations to focus on the remaining risks.

- An emphasis on public policy development on three levels:

  1) Individual health behaviors

  2) The underlying relationship between income and education disparities and health status.

  3) Cooperation and coordination between providers, educators, etc. who are involved in the early intervention programs.

Appendix

CHATTANOOGA-HAMILTON COUNTY REGIONAL HEALTH COUNCIL BY-LAWS

ARTICLE 1

NAME AND PURPOSE

Section I. Name

The name of this organization shall be the Chattanooga-Hamilton County Regional Health Council (herein this document also referred to as the "Council").

Section II. Purpose

The purpose of the Chattanooga-Hamilton County Regional Health Council shall be to serve as the lead community based organization designated by the Tennessee Department of Health to be responsible for *community health assessment, regional health planning and the provision of input regarding funding decisions for health and health related initiatives.*

The role of the Council shall also be to monitor the health status of residents and recommend strategies to assure the health of persons residing in Hamilton County. The Council shall be responsible for:

1. Assessing the health status of the community and prioritizing the health needs.

2. Developing a community health plan that addresses identified health needs and includes goals and objectives, as well as outcome measures, and recommendations for interventions.

3. Identifying key resources and working through partnerships to facilitate the formation of other resources to address the needs of children and families in Hamilton County.

4. Serving as liaison between the community and health and medical related services, keeping all parties informed of pertinent issues, health plans, contributions and accomplishments.

5. Providing input where possible for the development of long-range strategic plans for other public and private agencies and organizations regarding health and health related matters.

6. Reviewing proposals and other funding requests in order to make recommendations to State and Federal agencies, foundations and other funding bodies.

ARTICLE II

MEMBERSHIPS AND TERMS

Section I. Ex-Officio (Non-Voting) Members

The persons occupying the following positions are ex-officio, non-voting, members of the Council.

1. Hamilton County Executive
2. Administrator, Chattanooga-Hamilton County Health Department (and/or Staff Designee)
3. Health Officer, Chattanooga-Hamilton County Health Department
4. Chairman of the Hamilton County Board of Commissioners' Committee on Health

Section II – Appointment of Members and Terms of Service

A. The membership of the council shall consist of 25 voting members appointed as follows:

Each of the nine (9) members of the Hamilton County Board of Commissioners may appoint one (1) voting member to the Chattanooga-Hamilton County Regional Health Council for a three-year term.

B. The Administrator of the Chattanooga-Hamilton County Health Department, shall recommend to the County Executive for approval by the Hamilton County Board of Commissioners the appointment of the remaining at-large members.

C. The terms of service for these persons shall be three (3) years.

Section III – Reappointment

Council Members may be re-appointed to serve additional terms by an appointing authority (County Commissioner or the County Executive) in keeping with the By-Law provisions of Section II.

Section IV – Vacancies

Vacancies occurring during the year will be filled (to complete an un-expired term) by the appropriate appointing authority (County Commissioners or County Executive).

Section V – Participation and Attendance

Council Members are expected to exhibit leadership qualities and high standards of personal integrity and service as they represent the community in carrying out the work of the Council.

Council Members are expected to take an active role in the conduct of the business of the Council including committee assignments and attendance at committee meetings as well as regularly scheduled Council meetings.

As Council Members representing the Council in their interactions with residents, public/private agencies and organizations, and the media, their official positions on health and health related matters should be in keeping with positions held by the Council.

The Council Chairperson will contact Council members who have unexcused absences for three (3) consecutive Council meetings. The chairperson will inquire as to the intentions of the member concerning future participation. Members who indicate that they intend to continue participation will be encouraged to do so. However, any members who have missed 75% of the Council meetings in a calendar year may be recommended to the appointing authority for removal from the Council.

ARTICLE III

OFFICERS, DUTIES AND TERMS

Section I – Officers

The Officers of the Council shall consist of a Chairperson and Vice-Chairperson who shall be elected annually by a majority of a quorum of the Council. Additionally, there shall be a Recording Secretary position permanently filled by the Health Department Administrator, (or Staff Designee).

Section II – Terms and Elections

The Chairperson and Vice-Chairperson shall be elected for one-year terms at the first meeting in each calendar year. A Nominating Committee shall be appointed by the Chairperson at least one month prior to the first meeting of the calendar year. This Committee will recommend a slate of officers. Others may be nominated from the floor. Consecutive terms can be served up to a maximum of three.

Section III – Duties

1. Chairperson. The duties of the Chairperson are as follows:
   a. To open meetings at the appointed time by taking the Chair and calling the meeting to order after ascertaining that a quorum is present.
   b. To announce the proper sequence of business in accord with the prescribed agenda.
   c. To recognize members who are entitled to the floor.
   d. To state and put to vote all legitimate questions.
   e. To enforce parliamentary procedures and rules relating to debate, order, and decorum.
   f. To expedite business compatible with the interests of members.
   g. To authenticate by signature all acts, orders, and proceedings of the assembly.
   h. To declare adjournment of meetings.
   i. May appoint up to two (2) voting Council members at large to the Executive Committee.

2. Vice-Chairperson. The Vice-Chairperson assumes the duties of the Chair if the Chair is vacant or is absent.

3. Recording Secretary. The duties of the Recording Secretary are as follows:
   a. To keep a record of the proceedings referred to as minutes.
   b. To keep on file all committee reports.
   c. To keep the official membership role.
   d. To make minutes and records available to members.
   e. To send out notice for each meeting fourteen (14) days in advance, when possible.
   f. To prepare the order of business (agenda) as determined by the Chairman.
   g. In the absence of the Chairperson or Vice-Chairperson to call the meeting to order and preside until the Chairperson or Vice Chairperson arrives. When such positions are vacant, the Recording Secretary will preside until the immediate election of chairperson pro tem.
   h. To provide logistical staff support as needed to the Council and its committees and subcommittees.

ARTICLE IV

MEETINGS AND QUORUMS

Section I – Meetings

The Council shall meet at least quarterly, on a day and at a time that is approved by the body. The location may be the Chattanooga-Hamilton County Health

Department or another appropriate location as determined by the Executive Committee. Notification of changes in meetings may be necessary from time to time, and these shall be formally communicated to members fourteen (14) days prior to the scheduled meeting.

Section II – Quorums

A simple majority of the voting members of the Council present at a Council meeting constitutes a quorum.

ARTICLE V

COMMITTEES

Section I – Standing Committees

The Standing Committees are as follows:

1. Executive Committee shall consist of all officers and all Standing Committee Chairs and up to two (2) voting Council members at large. Decisions made by this Committee subsequently must be ratified by the Council.

2. Community Health Planning Committee shall consist of Council members who are to take the lead in processes designed to assess the health status of persons residing in Hamilton County and prioritize their health needs. This group will have responsibility for drafting for the Council's consideration and approval the Community Health Plan for the Hamilton County Region. In so doing, this group may partner with key technical resources and with other groups, organizations and institutions who share an interest in assessing the health of our population and in developing strategies to address identified needs.

3. By-Laws Committee shall review and propose changes to the By-Laws as appropriate for consideration by the Council to be submitted to the Hamilton County Board of Commissioners for approval.

4. Nominating Committee is responsible for recommending a slate of officers to the Council to be voted upon. Should a Council officer be unable to complete the elected term, the Nominating Committee shall recommend to the Council someone to fill the un-expired term.

Section II – Other Committees

Other Council Committees may be established as deemed necessary by the Council Chairman.

Committee membership for Standing Committees, with the exception of the Community Health Planning Committee, will include only Council members.

Article VI

Changes To The By-Laws

Section I – Process for Changing By-Laws

The By-Laws Committee shall review and propose changes to the By-Laws as appropriate for consideration by the Council to be submitted to the Hamilton County Board of Commissioners for approval.